Province of
British Columbia
Ministry of
Health

MENTAL HEALTH CONSULTATION REPORT

A DRAFT PLAN TO REPLACE RIVERVIEW HOSPITAL

Canadian Cataloguing in Publication Data

Main entry under title:
Mental health consultation report

Bibliography: p.
ISBN 0-7726-0641-2

1. Mental health services - British Columbia. 2. Community mental health services - British Columbia. 3. Aged - Mental health services - British Columbia. 4. Riverview Hospital (Port Coquitlam, B.C.) I. British Columbia. Mental Health Services.

RA790.7.C3M46 1987 362.209711 C87-092078-2

Table of Contents

	Page
I. BACKGROUND	
A. The Consultative Planning Process	1
B. Philosophy and Principles	2
C. Target Population	3
D. The Need for Service Developments	4
E. Current Mental Health Services	4
II. THE REPORT	
A. General Community Services	8
B. Community Mental Health Support Services	9
1. Day Programs	9
2. Community Residential Care	9
3. Outpatient Treatment and Case Management	10
C. Hospital Care	11
1. Pivotal Role of Acute Care Hospitals	11
2. Medium/Long Term Inpatient Psychiatric Care	13
D. Services for the Elderly	15
E. System Coordination and Accountability	16
F. Recruitment, Training and Development of Personnel	17
G. Research	18
III. FISCAL STRATEGY	19
IV IMPLEMENTATION	21
V. CONCLUSION	23
VI. APPENDICES	
A. Resource Development Targets	25
B. Resource Development Funding Requirements	27
C. Summary of Recommendations	29
D. List of Contributors	33
E. References	43

I. BACKGROUND

A. *The Consultative Planning Process*

Riverview Hospital has served the people of British Columbia since the beginning of the 20th century. It has been the treatment, rehabilitation, and asylum centre for adult and elderly people with the most serious and disabling mental illnesses.

During the last 10 to 15 years, it has been generally recognized that care for the mentally ill lags behind the mainstream of health care in British Columbia. This is evidenced by the outdated and often dilapidated buildings at Riverview Hospital, with limited staffing and program resources available for effective treatment and rehabilitation, both within the institution and subsequently in community settings.

A consultative planning process was begun in the Summer of 1985 to address the need to replace outdated buildings at Riverview Hospital and, concurrently, to recommend improvements to the Province's over-all mental health service system.

The planning process concentrated on getting as much input as possible from the people involved in the British Columbia mental health system. Meetings and discussions were held throughout the Province to listen to views, issues, and needs for mental health care. Many individuals and groups participated in this task: consumers and providers of service, volunteers and professionals, employers and employees. All participants represented the legitimate views of various individuals, interest groups, communities, hospitals and educational institutions involved in the mental health system. The goal was to take the many points of view, identify common themes and issues, have further discussions on points of disagreement, and to work toward broad agreement — a consensus plan.

Over 250 written submissions were received by the Mental Health Services Division as well as numerous verbal presentations during meetings.

An interim report was sent to all participants in early 1986, from which further feedback and input was received. One hundred written responses and numerous verbal presentations were received as further input. The present report represents the next phase of the consultation process.

From the consultative process, the report has been written with the intention of integrating and synthesizing the vast amount of information and data received. An effort was made to extract the major themes, issues, principles, etc., from the consultative process. This involved a great deal of summarizing and interpreting of information, setting priorities based upon a sense of what is pragmatic, possible, effective, and efficient, while still honouring the consultative process. These working assumptions, premises, and principles need to be declared at the outset because they pervade the entire report. Following is a summary of the major premises and assumptions shaping the draft of the Mental Health Consultation Report:

1. The report covers mental health services to be provided to adults and the elderly by the *Provincial Mental Health System* composed of Riverview Hospital and general hospital inpatient and outpatient programs, community mental health centres, community residential and rehabilitation programs, and those social-service agencies providing services to mentally ill people which are funded by the Ministry of Health.

   A separate initiative is underway to develop increased mental health services for children and youth in the Province.

   The present report, also, does not cover the brief assessment and treatment services provided through Mental Health Centres for individuals experiencing significant but short term "problems in living"; nor does it consider future possible developments for mental health type services in the more traditional health care field (i.e., behavioural health).

2. A major priority of the Provincial Mental Health System is to provide assessment, treatment, and ongoing care for the group of

people (approximately 5% of population) with severe and disabling mental illness which is predominantly long-term, chronic and irreversible.

3. The availability of community residential beds, rehabilitation programs, and staff to support and manage the chronic patient in the community will reduce pressures on hospital psychiatric beds and thus help to limit the need to increase these most costly resources.

4. In general, a shorter hospital stay is desirable. It is predictive of a better outcome in terms of fewer days of rehospitalization, and better social adjustment for patients. Also, most patients managed in community programs after the acute treatment phase have better outcomes in terms of quality of life and social adjustment than comparable hospital patients.

5. The Provincial Mental Health Service relies upon a balance of medical, psychological, and social programs for the care and treatment of the mentally ill with appropriate ongoing review by physicians to monitor medical factors involved in mental illness.

6. There is a vital role for families and volunteers to play in caring for mentally ill people.

7. With the coordination and leadership of the Mental Health Services Division of the Ministry of Health there will be ongoing consultation and participative planning within each region of the Province for mental health care.

8. Any replacement facilities or programs for the mentally ill resulting from the present planning initiative will be in place prior to any reductions or adjustments to the existing facilities and programs.

9. The consultative planning phase has been long and deliberate. Implementation of planned changes will, similarly, be gradual and with ongoing consultation.

The following report presents the policies, principles, objectives, and recommendations for types of programs and facilities in a new mental health system. It makes recommendations about how these should work together and be managed. It is a "blueprint" to guide the development and improvement of mental health services in British Columbia.

B. Philosophy and Principles

The philosophy and principles of the mental health system are extremely important to develop and articulate at the outset. In broad general terms, they set the tone, mission, and direction for the services to follow. They act as standards and goals for future reference, and as guidelines to performance at all levels within the system.

The mission of Mental Health Services Division is to ensure that the people of British Columbia receive well organized and effective mental health services and that the mentally ill of all ages experience a quality of care consistent with that of physical health care in the Province. In working toward this mission, Mental Health Services Division adopts the following *philosophical core values*:

1) Mentally ill people have the same personal rights enjoyed by the general public: the right to quality health care, to determine personal goals, to access community services, and the right to privacy. Mental illness involves impaired perception and judgment, which makes the protection of these rights particularly important. Within their ability to know and judge, patients have the right to refuse treatment as well as to have the least intrusive treatment possible. They have the right to adequate and individualized care, including direction and management, when their own or public safety is at risk.

2) Mental health treatment and rehabilitation should be provided in settings which are most appropriate to the medical, psychological and behavioural needs of the individual.

3) Mental health services should work to respect the human dignity of people with mental illness.

4) Mental health services should work to facilitate and support the integration of mentally ill people into their families and communities wherever possible.

5) In consultation with families and communities, Mental Health Services Division should work to develop individuals' mental and behavioural potential to maximize quality of life, in as normal a lifestyle as possible.

In addition to these philosophical core values, there are a number of important *service principles* which should be adopted in order to provide quality services to mentally ill adult and elderly people.

1) **Comprehensiveness:** The mental health service system should be characterized by comprehensiveness. Mentally ill people require many kinds of service, some of which are active treatment, housing, socialization, training, medication, etc.

2) **Coordination of Care:** A comprehensive system of services delivered by a variety of agencies requires well coordinated organizational and administrative relationships among the services. Coordination is particularly important because mentally ill people are often unable to seek out and negotiate for care. Coordination also ensures that services are not unnecessarily duplicated, that service gaps are minimized, and that arrangements exist for cooperation among providers in the service of individual patients.

3) **Continuity of Care:** Even in a well coordinated system of services, it remains necessary to facilitate the movement of patients from one service to the next, providing for all the patients' needs during transitional periods when they must move from one type of service to another. The principle of continuity of care should be applied, especially in the process of discharge planning, because of the major transition from hospital to community, the attendant risk of relapse, and the magnitude of costs to the patient and the system in the event of relapse.

4) **Availability and Accessibility:** A service system should be characterized by availability and accessibility of services. Many patients are very poor, lack transportation, and are especially likely to be discouraged by barriers of all types. Services, therefore, should be offered under time, location, physical, psychological and financial conditions that make it possible for patients to use those services when needed.

5) **Accountability:** The mental health system should be accountable for the quality and efficiency of the care that it delivers to enhance effectiveness and efficiency of services.

C. Target Population

The report primarily addresses the serious mental health problems of adult and elderly people. They may have an *acute illness* requiring short term hospitalization and outpatient treatment, or they may have a *chronic illness*, with long-lasting symptoms and disabilities, repeated treatment episodes, dependent life style, and a need for indefinite community support services.

These are people whose diagnoses include schizophrenia, psychosis, organic brain syndrome, and major affective disorders. Usually, there is a disability arising from the illness with partial or total inability to meet normal responsibilities in social, work, and home settings.

In the past, many have required medium to long-term hospitalization at Riverview Hospital, however, significantly more formerly institutionalized patients are now in community-based programs as a result of the improvements made in pharmaceutical technology, accompanied by advances in psychotherapies, rehabilitation, and patient management methods.

One or two decades ago, those served in the community were predominantly older, chronically mentally ill, with histories of lengthy institutionalization. They tended to be compliant with treatment and responsive to more simple custodial care. Although many of these people remain in the Community Residential Care Program, well served by Mental Health Centres, a significant number of today's caseloads are very different. It is estimated that 25 - 30% of outpatient mental health patients are those who have been described as difficult and multi-system users. The young (ages 18 - 35) are over-represented in this group. Often they have had little or no hospitalization, are noncompliant with traditional office-based treatment, and have few personal care, social or job skills. Substance abuse is often an exacerbating problem. Although this group is relatively small, it is important to note, as its members tend to use proportionally more service, often in a revolving-door fashion. There is much evidence to suggest that this group may be consuming a disproportionately large part of our mental health care dollar.

The report also focuses on the needs of elderly mentally ill people. They are literally the most fragile and vulnerable group. Because of their isolation, they may not seek out help. When they

do get help, there is a complicated interplay between physical illness, brain dysfunction, and psychological conditions which makes accurate diagnoses and effective treatment extremely challenging.

D. *The Need for Service Developments*

The prevalence of mental illness is quite alarming in modern society. Epidemiological estimates for the U.S. and Canada indicate that up to 30 percent of the population experience a significant psychiatric disorder at some time in their lives, and up to 20 percent at any particular time. Of these, approximately 5 percent were found to be suffering from a *major mental illness* (schizophrenia, psychosis, organic brain syndrome, affective disorder).

More simply stated, approximately one in four Canadian families are likely to be directly affected by the devastating impact of mental illness, with the profound personal, social and financial losses associated. In British Columbia, this means that as many as 100,000 adult and elderly persons are afflicted with a major mental illness at any particular time, and three times as many from less severe disorders.

A proportion of these people cope on their own with the help of family and friends. Some are adequately treated at home by their family doctor; however, a significant group requires specialized treatment, follow-up and community support services. It was reported during the consultation process that a substantial shortfall in mental health services exists in British Columbia.

E. *Current Mental Health Services*

Today, mental health services are delivered, not by one agency, but by a complex and interwoven collection of agencies and groups of providers that have arisen within the last 50 years, most within the last 25 years. The mental health service system has changed from a single, central, Provincial mental health institution that was the only resource responding to the needs of mentally ill persons in British Columbia, to the present array of services that includes:

a) **General hospital** services in 27 designated psychiatric inpatient units with a total of 627 inpatient beds, some specialized for short-term assessment and treatment. The majority of units are devoted to general psychiatric practice, however, there are a number of "specialty" units in the Lower Mainland (e.g., short term assessment and treatment, schizophrenia, affective disorder units).

b) **Special Extended Care** is provided to behaviorally disturbed elderly mentally ill people in six units, with a total of 153 beds.

c) **Outpatient hospital** services supporting both community and inpatient service needs. These include day hospitals, affective disorder clinics, STAT units, etc.

d) **General medical practitioners and psychiatrists** providing primary mental health care from community offices and consulting with Mental Health Centres and Community Care Teams.

e) **Provincial mental health** services which have extended their care to direct management of mentally ill people in the community through the 54 local Mental Health Centres and sub offices, with a total staff of 501. There are about 12,000 patients in treatment.

f) **Riverview Hospital**, consisting of 1,306 beds; 400 in the Geriatric Division, and 906 in the Adult Division, providing specialized institutional care to people with the most seriously debilitating mental illnesses. A staff of 1,654 FTE's provide many medical, rehabilitative, and social services to these patients.

g) **The Greater Vancouver Mental Health Service Society** with eight Community Care Teams and three specialized facilities serving chronically mentally ill people. There are about 3,300 patients in treatment.

h) **Private citizens** and *nonprofit societies* which provide residential facilities, boarding homes, group and family homes, emergency shelters, crisis centres, individual counselling services, and achievement centres. More than 2,700 individuals are receiving residential services; more receive other uncounted services.

i) **Other ministries** and *volunteer agencies*, including the Ministries of Education, Attorney General, and Social Services and Housing.

Estimated annual costs of all health services in British Columbia are now well over $3 billion, of which approximately $250 million is devoted to the care of mentally ill people.

The broad spectrum of required services for mentally ill persons is reflected in this complex structure and the care of any single person may cross many different boundaries of government, funding agencies, and service organizations.

Mental health resources are used in different ways and to different extents throughout the Province. These differences are due to local priorities, ability to attract service providers, complementary facilities and services, migration of persons in need, etc.. Some differences reflect optimum strategy while others reflect local opportunities to improve the mental health system.

II. THE REPORT

Recommendations in this report are built around a number of key assumptions and beliefs. Firstly, is the belief that treatment and care can be provided in *community* programs and facilities for all but the most seriously mentally ill. Mentally ill people are optimally treated in an environment that permits contact with the rest of society, offers access to mainstream social institutions, demands independent functioning, is relatively noncoercive, and encourages contact with family and friends. If patients are expected to ultimately live in the community, then that is the best place for them to learn the skills they will need to function there.

Serious mental illness is most often resistant to strategies for prevention or cure. Rather, mental health programs must be aimed at managing and caring for the illness in much the same way as many physical illnesses, such as diabetes, hypertension, and chronic arthritis. We do not know how to prevent or cure these diseases, but we do know how to manage them clinically for the benefit of the people experiencing the illnesses. Effective community treatment programs for the mentally ill, therefore, need to be ongoing rather than time-limited; they must be aimed at minimizing dysfunction and at supporting patients in making a stable adjustment to community living.

Underlying this move to community-based treatment is the firm belief that the mentally ill should be united as much as possible with their families, friends, and local community environments in order to reinforce the whole *normalization* effort underlying mental health rehabilitation. Wherever feasible, families should be encouraged and supported to be involved in the care of their loved ones. When families are not available, there should be an effort to recreate the *family-like* living environment for the mentally ill person. Mental health boarding homes should be designed and operated in terms of size, atmosphere, and activities consistent with this family principle.

The Plan is also based on the firm belief that general hospitals providing acute psychiatric care must play a *pivotal role* in the model of community-based treatment and care of the mentally ill. There are compelling reasons for treating patients needing short term hospitalization in local general hospital psychiatric units. The growing importance of biological modalities for diagnosis and treatment, the frequency of complicated medical problems accompanying acute psychiatric illness, the need for family involvement in assessment, treatment, and discharge planning, and the continuity required between inpatient and aftercare programs all argue for treatment in the community hospital, which offers medical expertise, sophisticated equipment, and proximity to patients' social networks. If psychiatric units in general hospitals are properly designed and staffed within the context of a co-ordinated system of mental health care, they can provide acute care to all but the most difficult patients.

There are some patients, however, who will not benefit from community-based mental health programs, or from general hospital psychiatric unit programs. These people will require medium to long term treatment, rehabilitation and protective asylum. A Provincial capacity to handle these patients should be part of the plan to replace Riverview Hospital.

Throughout the report is evidence of a firm commitment to a particular model for the treatment and rehabilitation of mental illness. There must be sufficient expertise and resources in the mental health system to assure that *biological*, *psychological*, and *social* factors underlying mental illness and arising as a result of the illness can be addressed in programs throughout the continuum of care.

During the consultation process, respondents delivered a consistent message that the system has too few resources to meet the needs of seriously mentally ill people. There was broad concern expressed that the access to and quality of mental health care should be equivalent to physical health care in British Columbia. Mental illness has a primary biological base and requires medical assessment, diagnosis, and treatment like any other physical affliction, yet the resource disparities compared to the physical health

system were clearly noted. It was suggested that planning for mental health services in the future must address this resource disparity.

Mental illness affects people in different ways, at different times of their illness. Hospitalization for varying lengths of stay may be required for assessment, stabilization, and treatment. Other people may benefit from counselling/therapy and support and be able to continue living with their families and in their communities. For some people, long term rehabilitation and supportive housing is necessary to help them achieve some independence and to reduce the need for rehospitalization.

The mental health service system must be planned and managed to provide a continuum of services corresponding to the legitimate needs of patients at the varying stages of their mental illness. The major components on the continuum of mental health care are General Community Services, Community Mental Health Support Services, and Hospital Care, each having important roles and responsibilities in the care of mentally ill people.

A. General Community Services

British Columbia communities are well provided with people and resources dedicated to helping those in need. There are individuals, families, volunteer groups and societies willing and able to help the mentally ill live as happy and normal lives as possible in the community.

Families are a valuable resource in caring for mentally ill relatives. Family members often serve as advocates, supports, medication monitors, guardians, community relations facilitators, and transportation providers. They provide many of the rehabilitation functions necessary for community living and fill in many of the gaps that exist in the service network. These families require support and education to reinforce their vital role in the care and rehabilitation of mentally ill relatives.

(1) **The vital role of families in the rehabilitation of mentally ill persons should be encouraged and strengthened.**

(2) **Consideration should be given to increasing assistance to families looking after their mentally ill relatives.**

Volunteers, both individuals and organizations such as the CanadianMental Health Association and the Friends of Schizophrenics, also represent a significant resource for the care of the mentally ill. They are organized to offer friendship, support, and links to other community resources. They provide daily structure and many activities to increase the quality of the mentally ill person's life, and help the normalization process. Often they provide assistance with food, clothing, housing, and recreation.

(3) **The role of volunteer groups should be recognized in the continuum of services for the mentally ill.**

(4) **Methods should be developed to assist and coordinate these groups within the network of mental health services.**

Many services required by the mentally ill are available as part of the British Columbia social service and health care system. General medical practitioners play a key role, often providing the first assessment, treatment, and management of mentally ill persons. Physicians will continue to be primary health care givers and "gatekeepers" for those with serious mental illnesses to access specialized psychiatric and mental health services. In playing this key role, physicians must also work within the broad multi-disciplinary framework of service delivery in the context of a "bio-psycho-social" model of mental health.

(5) **The role of the physician as a primary practitioner in the treatment of mental illness and as a "gatekeeper" for specialized psychiatric and mental health services should be recognized and strengthened.**

(6) **Community mental health programs should coordinate, consult, and liaise closely with general medical practitioners involved in the care of people with mental illness.**

As part of general community services resources for housing, employment, education/training, and social/recreational activities are available to the general public as well as to persons with mental illness.

(7) Participation by mentally ill persons in social programs provided through general community services should be encouraged wherever possible as an opportunity for social integration and normalization.

(8) There should be consultation and coordination with local community representatives and groups to help plan for the needs of their mentally ill residents.

(9) Wherever possible, support should be given to help general community services to be active partners with the more formal mental health services in caring for the mentally ill.

The general public is a resource for the care of mentally ill members of the community. An informed, tolerant, supportive public presents opportunities for mentally ill people to participate in the community and to be cared for close to home.

(10) Ongoing public education should be conducted to increase understanding and acceptance of mentally ill people living in the community.

B. Community Mental Health Support Services

Mentally ill persons living in community settings require various kinds of supports and services at different points in their lives. Some services are essential to basic community living of patients and should be in place before they are discharged from hospitals (eg. housing assistance, income support, medical follow-up/monitoring, crisis management, access to hospital for acute episodes, and case management for overall coordination of care). Other services are necessary if patients are to improve their functioning: Psychosocial therapy, training in life skills, vocational training/work activities, family support services, self-help networks, and transportation. Finally, to enhance their quality of life, leisure activities are needed.

(11) Community-based treatment of the mentally ill should have distinct medical treatment/management, crisis response, housing, day program and vocational/work services.

1. Day Programs

Psychiatric/medical treatment is often necessary during acute episodes to stabilize, control, or ameliorate chronic mental illness. Day programs, on the other hand, are required on an ongoing basis to help maintain patients in community settings and to help them adjust to the disabilities imposed by the illness. Rehabilitation services, such as vocational training/work activities, training in life skills, and self-help networks enable patients to function with the least possible disability and disruption to their lives. Day programs should assist the mentally ill to become more socially and economically independent. Such programs should be carefully coordinated with the other parts of the mental health service system in any given geographic area in order to meet local service needs in the most effective manner possible.

(12) Improving care for the mentally ill requires increased emphasis on Day Programs providing vocational training/work experience, life skills training, structured daily activities and social/recreational opportunities.

(13) Day Programs should be available for each region of the Province reflective of the needs of the mentally ill in that region.

2. Community Residential Care

Mentally ill persons who are ready to leave hospital often need support and rehabilitation while they continue making adjustments toward normal living. Many are unable to live alone or with families, and require supportive housing and supervision.

The mentally ill are not a homogeneous group. They experience different kinds and levels of disability, require varying levels of follow-up and care and are capable of differing levels of independence. The residential care program built on a family home care model whenever possible should have a range of housing types which will match the needs of the various groups of patients. These should include the following types:

a) **Supportive Housing.** Residential settings for stabilized clients providing the support and security of a home, with a minimum of supervision, assistance and therapy.

b) **Personal Care.** Residential settings that provide bed, meals, and assistance with light housekeeping in a supportive environment. This type of setting is intended for clients who are able to live with minimal supervision and whose main requirement is residential and perhaps medication monitoring. They will spend most of their days out of the home.

c) **Intermediate Care Facilities.** Residential settings for clients who require significant behavioural management in medium to long-term care, providing a safe, stable, structured environment and significant supervision. Clients are followed up by Mental Health Centre or Community Care Team staff.

d) **Special Care.** Settings for clients requiring intense therapeutic programming and nursing care in a safe structured environment. Therapeutic and rehabilitation programs are run by professional staff in liaison with local Mental Health Centre or Community Care Team staff.

(14) **Whenever possible, the residential care program should use a *family home care* model for housing types, in conjunction with regular access to structured day programs and organized case management services through Mental Health Centres.**

(15) **An adequate number and ample range of housing types should be established (Supportive, Personal, Intermediate and Special Care Facilities).**

(16) **Within residential settings there should be a sufficient number of beds designated for respite and non-medical emergency purposes to meet the needs of each area.**

The present method for funding the Community Residential Care Program adjusts per diem rates according to the "level of care" at which the resident is functioning. There was a broad support for shifting the reimbursement method to one that more clearly supports improvement in resident functioning by funding individual facilities on the basis of program standards.

(17) **The current per diem funding method based on the "level of care" system should be reviewed with a view to developing a means of funding residential facilities to provide *specific programs* for specific client types.**

(18) **Residential programs should develop program standards, be awarded on a *tender basis*, and funded by means of *performance contracting*. There should be a formal system to monitor and evaluate delivery of services.**

(19) **Formal *standards of care* should be developed for each residential care setting, maintained and monitored through a cooperative effort between Mental Health Services Division and associations representing the operators of residential facilities.**

3. Outpatient Treatment and Case Management

Community Mental Health Centres (CMHCs), including Community Care Teams in Vancouver, are major providers of outpatient services to the mentally ill. The shift of care from institutional to community settings requires a continuation of comprehensive services for which CMHCs assume a major responsibility, especially for the mentally ill who are unable to meet their own needs.

For the more than 50 percent of the chronically ill population living at home, or for those with positive ongoing relationships with their families,

programs and respite care should be provided to enhance the family's ability to provide a support system to their relatives. Where the use of the family is not feasible, the patient must be linked up with a formal community support system.

(20) As resources are reallocated from institutional to community settings, CMHCs should take a lead role in coordinating local mental health services and facilitating access to appropriate services for mentally ill persons.

(21) CMHCs should provide outpatient assessment, treatment, outreach, emergency and after-hours services to their clients.

Due to the nature of mental illness, former hospital patients living in the community are at risk to become lonely, frightened, and isolated. Often there is a reluctance or fear to comply with treatment and rehabilitation plans and thus acute symptoms of their illness may return. A mechanism is needed to provide active outreach, follow-up, and linkages with mental health programs for these people to help reduce rates of rehospitalization.

(22) A system of responsibility for mentally ill persons living in the community should be established to ensure that each patient has one person responsible for his/her care in the case management model.

An important role of CMHCs is to follow up and manage patients after they have been discharged from hospitals. Many of these mentally ill persons have significant biological bases to, or consequences of, their illness. The continuum of care between biological and psychological/social programs is very important.

(23) CMHCs should require appropriate medical *assessment* and ongoing *medical monitoring* for all their mentally ill clients.

(24) There should be formal clinical relationships between CMHCs and hospitals on a geographic basis for the purposes of making referrals and effective discharge planning.

(25) CMHCs should liaise and consult closely with *general practitioners* and *community psychiatrists* of patients in their programs to ensure effective communication, planning and coordination of services.

C. Hospital Care

1. Pivotal Role of Acute Care Hospitals

Even with new psychotropic drugs and improved community care, there are some patients who will require hospitalization from time to time. The acute care general hospitals play a pivotal role for the mentally ill in local communities. They are responsible for providing emergency assessment, stabilization and short term treatment for people who are experiencing episodes of acute psychiatric illness who cannot be managed at home or in another residential setting and require quality medical/nursing treatment and management. Typically, treatment is short-term, i.e., up to 30 days before discharge. There are some patients, however, whose treatment may go beyond 30 days because of extenuating clinical circumstances.

There are three levels of general hospitals providing psychiatric care, each with varying roles:

a) General hospitals with no designated psychiatry beds, providing care through the Emergency Department and general medical beds. The role of these *local hospitals* is to provide initial assessment, screening, stabilization, and medical/nursing management of people with acute psychiatric disorders. Patients who are acutely disturbed or hard to manage will be transferred to a designated psychiatric unit within the district.

b) General hospitals with designated psychiatry beds and providing either a direct or consultation service to the hospital's emergency department. The role of these *district hospitals* is to provide specialty psychiatric assessment, short-term treatment of

acute psychiatric illnesses and skilled psychiatric nursing management. District hospitals provide back-up services to local hospitals for patients who do not respond to standard medical treatment and management practices for psychiatric illnesses.

c) General hospitals with psychiatric units which are affiliated with the Department of Psychiatry, University of British Columbia, as teaching units. The role of these *teaching hospitals* is to provide the highest level of psychiatric assessment/treatment expertise available in a number of specialized areas. They may serve as a back-up referral or consultation resource for district hospitals throughout the Province.

Also, for the most difficult to manage patients in the Province, an *intensive acute care* psychiatric unit is required for short term assessment, treatment and stabilization.

(26) Each region of the Province should have sufficient inpatient psychiatry beds to meet the needs of the acutely mentally ill population.

(27) Each region of the Province should be relatively self-sufficient in its ability to assess and treat episodes of acute psychiatric illness in its population.

(28) Each general hospital in British Columbia should be prepared to assess and treat all acute episodes of mental illness.

Involuntary committal to a hospital is sometimes required when a mentally ill person is judged to be a danger to himself or others. The illness may pose a serious threat to his health and well-being, or it may be manifested through aberrant or hard to manage behaviours.

(29) Each general hospital should be designated under the *Mental Health Act* to allow for detention and treatment of individuals with mental illness.

(30) *Local general hospitals* without psychiatric units should have a secure room capability in their emergency department to handle hard-to-manage patients. There should be protocols in place to transfer these patients, if required, to the *district general hospital* with a psychiatric unit within the region.

(31) Each general hospital with a psychiatric unit should have a *secure room* capacity within the unit to manage and/or detain patients who are resistive or combative.

(32) An *intensive acute care psychiatric unit* should be developed in the Vancouver area to handle patients experiencing acute episodes of mental illness and who are also too violent or disruptive to be stabilized and treated in general hospital psychiatry units.

Acute psychiatric beds in Vancouver and other parts of the Lower Mainland are being dedicated for specialty psychiatric disorders. Some of these are for teaching and research purposes, while some others are strictly for treatment. Caution needs to be exercised to ensure that there are sufficient *general psychiatry beds* to meet identified needs for the area.

(33) Specialty psychiatric beds should be reserved for university teaching hospitals in the number and type to meet approved academic and research commitments.

(34) Planning and allocating of specialty psychiatric beds should be done in a consultative and coordinated way with the Hospital Programs and Mental Health Services Divisions of the Ministry of Health, and the University of British Columbia, Department of Psychiatry.

Regional coordination and collaboration among the component mental health services is essential, especially for access into hospital acute psychiatric resources, and subsequently access to community follow-up, housing, and rehabilitation programs.

In some areas of the Province, *Regional Psychiatric Coordinating Committees* are operating to streamline discharge planning, access to multiple services, and general service collaboration. This is a good model and should be further developed and more widely implemented.

2. Medium/Long-Term Inpatient Psychiatric Care

The Mental Health Plan gives an emphasis to developing community-based programs for care and management of mentally ill persons. Many long-term and seriously disabled psychiatric patients can be transferred from institutions to community-based facilities closer to their families and natural helping networks. General hospitals support this transfer of care by providing vital acute psychiatric services when necessary.

Nevertheless, there will continue to be a need for some medium/long-term psychiatric inpatient care and rehabilitation such as that now provided at Riverview Hosptial. This capacity must continue to exist for the benefit of "patients who do not fit" — the most severely and chronically ill, for whom adequate assessment and treatment is not possible within the acute hospital or in community outpatient settings. This capacity is required for cases where the individual or the community must be protected and also when the mental illness is so severe that patients require structure and good nursing care, not to mention the safety and security of an asylum-like environment. It seems to be generally accepted that 15 persons per 100,000 population require this level and type of service at any particular time. These people fall into the following six groups:

a) Elderly patients suffering from dementia, psychosis, and medical illness who may be dangerous to themselves or others and cannot be managed in small acute care inpatient units, nursing homes, or other community care programs.

b) Mentally handicapped patients with psychiatric disorders who may be assaultive or display aggressive behaviour. They require a low stimulus environment, skilled drug therapy, and behaviour therapy.

c) Patients who are brain-damaged and have serious loss of impulse control who require safe residential units with medical, pharmacological, behavioural, and physical therapy.

d) Schizophrenic patients who are chronically psychotic, assaultive, or suicidal. They require a safe, secure setting with sophisticated psychopharmacology, behavioural, and psychotherapeutic methods.

e) Chronically schizophrenic patients who exhibit behaviour that makes them vulnerable to exploitation. These patients require programs based on a psychosocial rehabilitation model focusing upon teaching skills necessary to live outside of hospital. These programs can be developed in moderately staffed residential units.

f) Patients with severely dysfunctional behaviour (eg. severe personality disorders, sexual disorders, drug and alcohol complicated disorders) as a component of their psychiatric illness.

(35) The commitment to provide medium/long-term psychiatric inpatient care for the most seriously mentally ill and "at risk" patients should be reaffirmed.

Regionalization of medium/long-term psychiatric inpatient facilities is a principle that has gained broad support through the consultative planning process. Planning must take into account such realities as population bases (present and future), availability of professional manpower in rural areas, and alternate resources that have been developed in some regions. These notwithstanding, there are major advantages to locating facilities closer to home communities, strategically located in the major regions of the Province. There are also significant advantages to be realized for the quality of care, and quality of life of patients in treatment by keeping the size of medium/long-term inpatient psychiatric units to the minimum level consistent with basic operating scale requirements.

It has been demonstrated in a number of jurisdictions that small inpatient units are well able to offer high quality psychiatric care, and to do so in a more personal and individualized manner than larger hospital facilities. This small-scale personalized approach to inpatient care is consistent with the overall theme in the report of providing required services close to people's homes, with as little intrusion as possible into their normal lives.

(36) A plan should be developed for up to 550 beds in small units for medium/long-term psychiatric inpatient care in strategic locations of the Province.

The medium/long-term inpatient care must be part of an *integrated system of mental health care*. Aside from a minority who stay in hospital for extensive periods, there is a regular flow of patients between hospitals and community-based programs. This is an inevitable occurrence for patients with serious and long lasting mental illness. Thus, it is important that the medium/long-term inpatient units are closely linked to community programs for service planning, preparing patients for discharge back to their homes or other settings, and when necessary, to facilitate re-entry into inpatient psychiatric care.

A comprehensive constellation of services for chronically mentally ill persons is required to improve care, to decrease fragmentation, and to ensure a smooth transition as patients move from one part of the care system to another. The concept is an expanded *"Community Mental Health Centre"* patterned after the successful model operating at Burnaby Psychiatric Services, providing the following array of services:

1. Outpatient treatment and case management.
2. Structured day activity and rehabilitation programs.
3. Residential programs.
4. Medium/long-term inpatient care.

These services, geared toward the medium/long-term care and treatment needs of the chronically mentally ill primarily, are intended to complement the specialized mental health services available in each community for those with short-term treatment needs.

(37) **Medium/long-term inpatient units should be developed as part of a constellation of services for the chronically mentally ill in conjunction with local Community Mental Health Centres or Community Care Teams.**

The constellation of mental health services may be composed of a number of entities — profit/non-profit, societies, community and volunteer groups, etc. The Community Mental Health Centre or Community Care Team would serve to manage those operations which it funds, and coordinate other services dedicated to the care of the mentally ill. Relationships with local general hospitals for emergency pychiatric and acute care treatment would be developed, with protocols clearly defined for admission, discharge, and follow-up of patients.

(38) The Community Mental Health Centre or Community Care Team should take responsibility for managing/coordinating the array of local services for the care of the chronically mentally ill.

Protocols should be developed between local general hospitals providing emergency and short term psychiatric treatment and the Community Mental Health Centre or Community Care Team providing outpatient treatment/management, day/rehabilitation, residential, and medium/long-term inpatient psychiatric care.

These medium/long-term inpatient units would provide medical, nursing, and a range of activity and rehabilitation programs designed to help the mentally ill person return to his optimal level of functioning, and when possible, to return to his home or to an appropriate community care setting. The units would be developed to provide an array of programs for different types of patients requiring medium/long-term inpatient care. It is likely, also, that a number of units would be designated in the Vancouver - Lower Mainland area for specialized medium/long-term inpatient care for certain groups of patients such as the psychogeriatric, organic brain syndrome, or the very difficult to manage.

The consultative planning process supported the idea of developing a "centre-of-excellence" within the medium/long term inpatient psychiatric system. This would consist of an "umbrella" organization of the inpatient units to plan and coordinate specialty clinical programs and academic/research initiatives to continue advancements in the assessment, diagnosis, and treatment for the serious mental illnesses.

(39) The medium/long-term inpatient psychiatric service units should develop a special "umbrella" capacity to plan and coordinate specialty clinical programs and academic research initiatives.

Allocation of medium/long-term psychiatric inpatient beds is based upon many factors. Firstly, the number of beds allocated for the Province is based upon experience in other jurisdictions which has found that 15 beds per 100,000 population is sufficient if community-based programs are in place. Distribution of these beds is based presently on relevant demographic information, present and future projections, prevalence data, and to some extent, utilization data.

(40) 550 beds for medium/long-term psychiatric inpatient care should be distributed throughout the Province in the following manner:

Vancouver/Lower Mainland	300 beds
Okanagan/Kootenay	100 beds
Vancouver Island	100 beds
North	50 beds

D. Services for the Elderly

The Mental Health Plan core values, philosophy, orientation, and services address many of the needs of elderly mentally ill persons. Some additional attention is required, however, for this group. Their numbers are rapidly increasing in our society, and they have unique health care needs associated with the aging process.

The consultation process and recommendations made in the Report from the Technical Advisory Group on Services to Meet the Mental Health Needs of the Elderly strongly supported maximizing community-based care for seniors with mental illness, with home care and family support strategies being used whenever possible. When circumstances require increased structure and management for elderly persons, there was strong support for this being done in *local care facilities*, either in the general hospital for acute care, or in local Continuing Care facilities when longer term nursing care is required.

(41) Resources should be dedicated to strengthening a local community-based care model for elderly persons with mental illness.

The British Columbia health care system provides many services for the elderly mentally ill population. General practitioners continue to provide medical management in the community. Local hospitals provide assessment and treatment when acute problems arise. The Ministry of Health's Continuing Care Divison provides ongoing home support and facility nursing care when elderly people can no longer cope on their own. Continuing Care also funds Specialized Geriatric Short Stay Assessment and Treatment Units in general hospitals. Each of these components provide valuable services, but it is generally recognized that additional specialized geriatric assessment, consultation, and short-term treatment is often required to help general health services care for the special needs of the elderly mentally ill.

(42) The development of mental health services for the elderly should be in conjunction with existing health care resources.

(43) The Mental Health Services Division should develop multidisciplinary outpatient teams associated with Community Care Teams and Mental Health Centres around the Province to provide back-up assessment and consultation to general practitioners, local hospitals, and continuing care facilities looking after elderly people with mental illness.

(44) The geriatric assessment and treatment outpatient teams should also develop a community support program for individuals living in their own homes and for families providing care for their elderly relatives.

The consultation process endorsed helping mentally ill elderly persons to remain at home and in their communities as long as possible. Nevertheless, there may be periods when

individuals, families, or continuing care facilities need temporary assistance to manage the elderly mentally ill, either because of special problems associated with the elderly mentally ill group, or for respite purposes.

(45) The Mental Health Services Division should manage a number of local specialized mental health residential care beds for the elderly, offering respite and short term residential care as a further support to families and continuing care facilities in the area.

Treatment and care for the elderly mentally ill will be extended, with greater coordination at local levels through a community-based treatment model, and with close working relations among general practitioners, mental health specialists for the the elderly, hospital and residential care staff. The consultation process and the Technical Advisory Group on Services to Meet the Mental Health Needs of the Elderly affirmed the continuing need for a limited number of medium-term specialized hospital beds for specialized inpatient assessment and treatment of the mentally ill.

(46) **The Mental Health Services Divison should redevelop a limited number of hospital beds for medium-term specialized inpatient assessment and treatment of the elderly mentally ill, as part of the overall strategy for medium/ long-term psychiatric inpatient care.**

Critical underpinnings to an effective mental health care system for the elderly are education, training and research. Increased awareness of the mental health needs of the elderly, skilled mental health personnel using up-to-date assessment and treatment techniques, and the ability to develop better care methods for the elderly were frequent themes coming out of the consultation process and the Technical Advisory Group.

(47) **Mental Health Services Division should provide opportunities and funds for evaluation and applied research related to specialized assessment and treatment methods for elderly mentally ill people.**

E. System Coordination and Accountability

The Provincial Mental Health System consists of an array of service providers, including hospitals, Mental Health Centres, contracted agencies and societies, community psychiatrists, and general practitioners. There are three branches within the Ministry of Health involved in delivering and funding mental health services: The MentalHealth Services Division, Hospital Programs, and the Medical Services Plan. In addition, there are three different ministries providing specialized services to people with mental illness: the Ministries of Health, Social Services and Housing, and Attorney General.

The coordination and organization of the components of the mental health system has a number of outcome objectives:

a) Over-all quality and continuity of care for people with mental illness.

b) Effective planning, monitoring, and management of the mental health system.

c) Efficiency and cost-effectiveness.

d) Maximum utilization of resources for patient care.

e) Standardization of available services in each region.

f) Equitable distribution of facilities and services.

Strong mechanisms for systems coordination and accountability need to be developed to ensure that an improved Provincial Mental Health System works effectively to meet patients' needs while maximizing the benefit from available resources.

(48) **Mental Health Services Division should continue to take the lead role on behalf of the Government for providing the integration, coordination, and accountability concerning all services for the mentally ill among Ministries of the Provincial Government, Divisions of the Ministry of Health, and other appropriate nongovernment bodies which receive Government funding.**

(49) Mental Health Services Division should work closely with Hospital Programs for policy development, program planning, and funding for all *in-hospital mental health care*.

Planning, coordination, and accountability is also important at regional and local levels to develop a system that meets the needs of the mentally ill in as effective and efficient manner as possible. A mechanism for continuing consultative planning and system coordination is required.

In recognition of the potential for greater responsiveness and efficiency in the management and future redirection of Riverview Hospital, it has been suggested that consideration be given to restructuring Riverview as a board-operated hospital within the context of a total system of care operated by the Mental Health Services Division.

There was support during the consultation process for society operation of medium to long term inpatient facilities. The affected unions, however, expressed support for government operated facilities.

(50) Broadly constituted Mental Health Advisory Boards should be formed within each region to advise Regional Managers of Mental Health Services regarding program needs, policy, and operational issues for the care of mentally ill persons in the area.

(51) Members should be appointed by the Minister of Health to represent key areas of the service system, with significant representation assured for general citizen and patient interest groups.

(52) For the purposes of planning, coordinating, and managing Provincial Mental Health Services, the Province should be divided into six regions:

a North
b Vancouver/Richmond
c Burnaby
d Fraser Valley/North Shore
e Vancouver Island
f Okanagan/Kootenays

(53) At local levels within each region *mental health coordinating committees* should be strengthened or developed to help define service needs, solve operational problems, and improve the abilities of programs working together for the benefit of mentally ill persons.

F. Recruitment, Training, and Development of Personnel

The staff involved in delivering mental health services ultimately determine the quality of care provided. The success of a plan is dependent upon highly motivated and skilled people working with the mentally ill. Highly trained staff — psychiatrists, general practitioners, registered and psychiatric nurses, psychologists, social workers, and occupational therapists — are needed in adequate numbers throughout the Province. Training and supervised experience is especially important in community mental health practice.

(54) A coordinated manpower strategy should be developed for recruitment, placement, and maintenance of mental health professionals in non urban areas of the Province.

(55) The Mental Health Services Division should have ongoing consultation and liaison with B.C. professional training schools to promote a community mental health focus in their relevant courses and supervised practica or internship programs.

(56) The Department of Psychiatry, University of British Columbia, in cooperation with the BCMA Section of Psychiatry, should provide comprehensive continuing psychiatric education aimed at increasing the knowledge and skills of *primary care physicians* in British Columbia.

Current staff at Riverview Hospital represent a valuable resource for the future mental health service system. For years professional and support staff at Riverview Hospital have provided high quality care to the most seriously mentally ill despite the considerable difficulties posed by the outdated physical plant. Nursing staff at Riverview are widely recognized throughout the province for their expert management and care of the severely disturbed psychiatric patient. It is essential that these skilled psychiatric nurses and other staff continue to work within the new system with its greater emphasis on community-based care. The various unions representing Riverview Hospital employees have a legitimate concern about the future employment of their members in the face of possible major system changes. There is, therefore, a natural basis for common concern by the Ministry and the unions in planning for changing mental health service requirements while preserving and enhancing the important skill-base in psychiatric care that exists among Riverview staff for the benefit of the broader service system.

(57) **The Ministry of Health should consult with the various unions representing Riverview Hospital employees within the terms of the relevant collective agreements.**

(58) **Implementation planning should address the interdependent need of the future service system and Riverview Hospital staff, particularly the large group of psychiatric nurses, to ensure that staff with specialized training and expertise are available to those individuals in need of care and treatment, and at the same time that current staff are assisted in taking on the new roles that will be required of them in future.**

G. Research

Research is an important investment in the future of mentally ill people. New advances are being made to unlock the secrets of mental illness that will help preventive efforts and improve assessment and treatment programs. The effectiveness and efficiency of the mental health system in the future will derive from the benefits of such research.

(59) **There should be a formal relationship between the Mental Health Services Division and universities in British Columbia to coordinate planning for mental health research.**

(60) **The Mental Health Services Division should establish a Centre for Mental Health Research and Development to coordinate research initiatives for treatment, technological developments, and demonstration projects designed to achieve advancements in mental health care.**

III. FISCAL STRATEGY

The consultation process to develop the Mental Health Plan has been overshadowed by the awareness of escalating overall health care costs. Many have expressed the fear that planned changes are only a facade for further resource reduction plans. On the other hand, others more sensitive to the pervasive need to control the tax burden generated by health care fear that the planning process has been a subtle instrument for generating new pressures for increased spending. It is clear from these perspectives that it is imperative that maximum effectiveness from existing resources be obtained. Any fiscal enhancements must be entertained within the overall economic reality of the Province. It has been reported by many that the mentally ill receive very "humble" health care. Therefore, the report is very clearly committed to maintaining existing resources.

Resources available for the care of seriously mentally ill people are in a vulnerable position at the present time. With the contemplated transfer of treatment and rehabilitation from an institutional to a community base, it is vital that the current level of funding be maintained. Past efforts have failed when appropriate funds did not accompany patients to develop community programs and facilities.

Mental health resources may also be vulnerable in the acute hospital system. There is a need for traditional medical programs to work cooperatively with psychiatric/mental health programs in ensuring an adequate share of health resources is available for the mentally ill. The British Columbia Medical Association recommended a formalized way of "protecting" mental health resources in the general hospital system. It is expected that a joint commitment within the hospital sector and the Ministryof Health to the legitimate needs of the mentally ill for hospital treatment, and a reasonable share of health care dollars for mentally ill people will be sufficient to adequately protect funding. The vulnerability of hospital based mental health services has been experienced in other provinces and will therefore have to be carefully monitored.

(61) The current level of financial resources at Riverview Hospital should be available for treatment, rehabilitation, and support of the mentally ill people transferred to community-based facilities and programs.

(62) A joint commitment should be made by the Hospital Sector and the Ministry of Health to the legitimate needs of the mentally ill for hospital treatment.

The current level of resources at Riverview Hospital for the treatment and rehabilitation of its mentally ill patients is estimated at $73 million. The resource reallocation strategy is based upon maintaining this funding level to replace services to the mentally ill currently provided through Riverview Hospital.

Reassignment of resources will be in the following service categories, with the estimated dollar figures shown. These figures can only be used as general guidelines which may have to be adjusted during implementation within the $73 million total available.

Medium/long-term psychiatric bed capacity	$34.1 M
Emergency/short-term psychiatric bed capacity	5.7 M
Family support services (G.P.'s, Psychiatrists, Case Management/ Treatment)	15.9 M
Community support services (day programs)	7.3 M
Community residential care	10.0 M
Total	$73.0 M

These funds are required to replace services currently provided to patients at Riverview Hospital, but most respondents identified that additional resources are required to meet a short-fall that now exists between current service capacity, and critical service requirements apart from the replacement process itself. It was

consistently reported that the focus must be on ensuring that current Riverview resources are fully applied in the replacement plan and its implementation. The transition phase will require careful management of the resource base associated with Riverview. Management and funding structures will need to be developed which optimize accountability and facilitate flexibility, responsiveness, and effective redevelopment of resources.

In the past, there have been major shifts from institutional to community care of mentally ill people in the U.S.A. and Canada. The results of these efforts have been mixed. Experience has shown that, where successful, there has been prior development of replacement facilities and programs before transferring people from institutional to community-based care.

The prior development of replacement facilities and services requires the availability of adequate "bridge" funding to permit current operations to continue until replacement ones are on-stream. The Plan cannot be successfully implemented without this additional interim funding capacity.

(63) **Replacement facilities or programs in community settings must be in place prior to any reductions or adjustments to existing facilities and programs at Riverview Hospital.**

(64) **Bridge funding must be available to permit the development of community-based facilities and programs while Riverview Hospital is gradually being scaled down.**

Throughout the consultation process and the exhaustive literature reviews on mental illness, the message has been clear that the prevalence and severity of mental illness in British Columbia challenges the available resources to continue to provide the same high quality of care which British Columbians have come to expect from their health care system.

IV. IMPLEMENTATION

Implementation will involve redeveloping and reallocating *existing resources* applied at Riverview Hospital for overall improvements to the mental health system. These are presented in Appendix A, entitled *Resource Development Targets*. Funding requirements entailed in the development of these resources are described in Appendix B, *Resource Development Funding Requirements*.

Consideration should be given to restructuring the hospital under a separate board in order to maximize its ability to address in a timely fashion the many needs for reallocation of resources embodied in this report.

The report calls for a 550 medium/long term psychiatric bed capacity, down from the current 1,306 beds at Riverview Hospital, with the balance of resources being reallocated elsewhere in the community mental health system in the form of other types of "beds," increased staffing, residential or day programs.

The gradual implementation process would see the following resource transfers from Riverview Hospital:

a) 218 staff FTEs for case management/outpatient treatment duties, resulting in 4,360 additional "units" of care being available to the mental health system;

b) 1,090 additional patient "places" for Community Support Programs (i.e., social/ recreational, and life skills/vocational);

c) 310 additional residential care beds for mental health care, divided between intermediate and special adult residential treatment facilities;

d) 60 psychiatric acute care beds to be added to the general hospital system.

The above resource reallocations are based upon the assumption that 300 current Riverview patients would be transferred to Continuing Care facilities in view of the fact that their mental illness has stabilized and they now require long term nursing care to manage predominating physical problems associated with advancing age.

The implementation process would be accomplished in two distinct stages. Stage one would see the development of community residential, day program, and case management/ outpatient treatment resources around the Province in order to reduce the Riverview patient population to approximately 500 over the first 3 years. Development of some additional acute care beds in general hospitals, and the pilot-testing of the small medium/long term inpatient unit concept in both urban and rural settings could also be undertaken in stage one. Stage two would include the development of the remaining medium/long-term inpatient units around the Province (assuming successful pilot results) to permit the final closure of the current Riverview facilities at the end of the five-year period.

The proposed staging of the implementation process in this way practically demonstrates the commitment that has consistently been made to prior development of community mental health resources as part of the Plan. New employment opportunities will be created in all parts of British Columbia and Riverview employees will be given additional training in order to fill important new roles in a revitalized community mental health service system. There would be a consistent focus throughout the implementation process on preparing staff to take on new responsibilities through a comprehensive, individualized training program. If the pilot test of the small medium/ long-term inpatient unit concept is not successful, then a substantial facility at Riverview, refurbished to meet program requirements, would be maintained until success is achieved or alternative hospital facilities developed to permit the complete replacement of the current Riverview facilities.

The proposed plan would be implemented over a five year period with a gradual and orderly shift to a system with a community-service set of values, philosophy, and resource allocation strategy.

Quality treatment and rehabilitation programs for the ultimate benefit of patients, their families, and society would direct all planning and

management initiatives, as a principal concern for the happiness and quality of life possible for the mentally ill.

The plan refocuses Riverview resources to promote normalization of life experiences, as close to natural family environments as possible. This would lead to an orderly transition period as patients presently in Riverview Hospital are assessed for their ability to be relocated to appropriate community settings, with sufficient mental health staff and programs to monitor, follow-up, and promote their readjustment outside the institution.

As community programs are brought on stream, there would be close monitoring and assessment to determine their effectiveness to achieve overall mental health system improvements. Implementation strategies must be flexible enough to respond to new service demands arising out of the British Columbia experience. The recommendations for resource reallocations in the attached schedules are targets based upon resources and analyses presently available in order to have a mental health system that is oriented to returning patients to, and maintaining them in community settings as close to home as possible. The final allocation of resources in each of the service system sectors would derive from the gradual implementation process.

(65) Implementation should be gradual and orderly with ongoing monitoring and evaluation to assure that adjustments to the mental health system are meeting the needs of the mentally ill.

Ongoing consultation would be maintained with local service mental health service providers, coordinating committees, and advisory boards to assure up-to-date information regarding the success of changes in programs to meet local priorities and conditions influencing the types of services required. Annual implementation reviews should be done in each region with an evaluation report.

(66) The consultative process should continue over the implementation period to assure that local priorities and needs for mental health services are being addressed.

Implemention would impose a period of instability for people with mental illness, as well as for staff who are involved in providing the services. This will be minimized through a gradual and orderly process. Nevertheless, caution must be exercised out of respect for the people who are experiencing the stress associated with change.

Especially for the mentally ill people who may be transferred from Riverview Hospital to community settings, there needs to be careful clinical assessment to determine the appropriate program and setting. Flexibility is required to make changes when placements are not working out.

(67) Patient transfers to community programs should be based on clinical assessment of need and ability, and should involve discussion with family members.

Staff, especially at Riverview, will experience the effects of change. The various collective agreements will be respected. Programs for reorientation or retraining of staff will be initiated to prepare them for new duties. Career counselling and relocation assistance programs will also be important parts of the implementation period. These efforts are in recognition of the vital roles and responsibilities that dedicated and skilled staff play in providing quality services to the mentally ill.

(68) Staffing changes required as part of the implementation process should be planned and carried out by the Ministry in consultation with the relevant unions to minimize the disruption or dislocation felt by individual staff members through appropriate staging, training, deployment, and counselling within the terms of the various collective agreements.

V. CONCLUSION

This consultation report proposes the development of a balanced service system with a comprehensive community care service closely coordinated with a graduated hospital care capacity in order to optimize the care of the mentally ill. It incorporates a commitment to provide additional support to individuals and families in their own communities as much as possible. The Report proposes a continuation of the successful consultative process, aimed at steering its gradual implementation and evolving responsive organizational mechanisms for service coordination and accountability.

The Mental Health Consultation Report owes its substance to the thousands of concerned citizens who have helped to shape it over the past year and a half. Similarly, the continued refinement of the proposed plan, and the responsibility for its early and successful implementation depends on the collective wisdom, energy, and heart of the people of British Columbia.

APPENDIX A

RESOURCE DEVELOPMENT TARGETS

Appendix A
Resource Development Targets

	Service Units for Riverview Replacement
FAMILY SUPPORT SERVICES	
• General Practitioners	
• Psychiatrists	
• Case Management/Treatment	4,360
COMMUNITY SUPPORT SERVICES	
• Social/Recreational	815
• Skills/Vocational	275
COMMUNITY RESIDENTIAL CARE	
• Intermediate	150
• Special Adult	160
HOSPITAL PSYCHIATRIC CARE	
• Emergency/Short-Term	60
• Medium/Long-Term	550

NOTES

1. Figures indicate resources required to replace services currently provided through Riverview Hospital. All of these resources are required to ensure that Riverview patients are appropriately cared for in new hospital or community settings.
2. "Service units" are beds for residential and hospital care, and "places" for family and community support services. A "place" represents the capacity to provide to one individual the appropriate services required on a "full-time" basis.
3. Family support services entail the provision of medical/psychiatric care and other professional mental health services on an outpatient case management and treatment basis to assist mentally ill individuals to live on their own, with family, or in a residential care setting. The 4,360 places required for replacement are comprised of 3,300 for the elderly and 1,060 for adults. An average caseload of 30 is assumed for case managers, with additional medical/psychiatric and other professional mental health treatment services provided assuming an average caseload of 60. The overall increase for all staffing required for replacement is, therefore, 218 FTE.
4. Community Support Services involve both social/recreational day activity programs, and life skills/vocational rehabilitation programs. Since some individuals may not be in full-time daily attendance at programs, one place may serve more than one person.
5. Community residential care is to be provided both at the intermediate and special adult care levels.
6. Hospital psychiatric care includes both emergency/short-term beds, and medium/long-term inpatient beds.

APPENDIX B

RESOURCE DEVELOPMENT FUNDING REQUIREMENTS

Appendix B
Resource Development Funding Requirements

	Daily Unit Cost ($)	Annual Operating Funds ($M) For Riverview Replacement
FAMILY SUPPORT SERVICES		
• General Practitioners		
• Psychiatrists		
• Case Management/Treatment	10	15.9
COMMUNITY SUPPORT SERVICES		
• Social/Recreational	15	4.3
• Life Skills/Vocational	45	3.0
COMMUNITY RESIDENTIAL CARE		
• Intermediate	65	3.6
• Special Adult	110	6.4
HOSPITAL PSYCHIATRIC CARE		
• Emergency/Short-Term	250	5.7
• Medium/Long-Term	170	34.1
Totals		73.0

NOTES

1. Figures in this table relate to the corresponding "Resource Development Targets" in Appendix A, according to the various daily unit costs indicated. The best current estimate of the total resources applied to the care of patients of Riverview Hospital is $73 million in annual operating funds. Total annual operating costs for all resources required to replace services currently provided through Riverview Hospital have also been estimated at $73 million in constant 1986 dollars.

2. Family Support Service costs for case management and treatment have been estimated at $10 per place-day. Case managers are assumed to have an average caseload of 30, and average annual salary and benefits of $40,000. Treatment staff caseloads are assumed to be 60 on average, with about $140,000 annually available for this caseload to meet medical/psychiatric and other professional treatment requirements.

3. Community Support Service costs are estimated as $15 per place-day for social/recreational programs (assuming daily operations except for statutory holidays), and $45 per place-day for vocational rehabilitation programs based on a five-day per week operation.

4. Community Residential Care operating costs are estimated at $65 per resident-day for intermediate level care for those current Riverview patients deemed capable of managing in a focused residential program, and $110 per resident-day for a new special care level for adult Riverview patients requiring intensive staffing and program support in order to manage in a community residential care setting. The daily user charge is included within these overall cost estimates to reflect the total cost of care involved.

5. Hospital Psychiatric Care costs are estimated at $300 per patient-day for intensive acute psychiatric care, $250 per patient-day for general acute psychiatric care, and $170 per patient-day for medium long-term inpatient psychiatric care.

APPENDIX C

SUMMARY OF RECOMMENDATIONS

Summary of Recommendations

(1) The vital role of families in the rehabilitation of mentally ill persons should be encouraged and strengthened.

(2) Consideration should be given to increasing assistance to families looking after their mentally ill relatives.

(3) The role of volunteer groups should be recognized in the continuum of services for the mentally ill.

(4) Methods should be developed to assist and coordinate these groups within the network of mental health services.

(5) The role of the physician as a primary practitioner in the treatment of mental illness and as a "gatekeeper" for specialized psychiatric and mental health services should be recognized and strengthened.

(6) Community mental health programs should coordinate, consult, and liaise closely with general medical practitioners involved in the care of people with mental illness.

(7) Participation by mentally ill persons in social programs provided through general community services should be encouraged wherever possible as an opportunity for social integration and normalization.

(8) There should be consultation and coordination with local community representatives and groups to help plan for the needs of their mentally ill residents.

(9) Wherever possible, support should be given to help general community services to be active partners with the more formal mental health services in caring for the mentally ill.

(10) Ongoing public education should be conducted to increase understanding and acceptance of mentally ill people living in the community.

(11) Community-based treatment of the mentally ill should have distinct medical treatment/management, crisis response, housing, day program and vocational/work services.

(12) Improving care for the mentally ill requires increased emphasis on Day Programs providing vocational training/ work experience, life skills training, structured daily activities and social/recreational opportunities.

(13) Day Programs should be available for each region of the Province reflective of the needs of the mentally ill in that region.

(14) Whenever possible, the residential care program should use a *family home care* model for housing types, in conjunction with regular access to structured day programs and organized case management services through Mental Health Centres.

(15) An adequate number and ample range of housing types should be established (Supportive, Personal, Intermediate and Special Care Facilities).

(16) Within residential settings there should be a sufficient number of beds designated for respite and non-medical emergency purposes to meet the needs of each area.

(17) The current per diem funding method based on the "level of care" system should be reviewed with a view to developing a means of funding residential facilities to provide *specific programs* for specific client types.

(18) Residential programs should develop program standards, be awarded on a *tender basis*, and funded by means of *performance contracting*. There should be a formal system to monitor and evaluate delivery of services.

(19) Formal *standards of care* should be developed for each residential care setting, maintained and monitored through a cooperative effort between Mental Health Services Division and associations representing the operators of residential facilities.

(20) As resources are reallocated from institutional to community settings, CMHCs should take a lead role in coordinating local mental health services and facilitating access to appropriate services for mentally ill persons.

(21) CMHCs should provide outpatient assessment, treatment, outreach, emergency and after-hours services to their clients.

(22) A system of responsibility for mentally ill persons living in the community should be established to ensure that each patient has one person responsible for his/her care in the case management model.

(23) CMHCs should require appropriate medical *assessment* and ongoing *medical monitoring* for all their mentally ill clients.

(24) There should be formal clinical relationships between CMHCs and hospitals on a geographic basis for the purposes of making referrals and effective discharge planning.

(25) CMHCs should liaise and consult closely with *general practitioners* and *community psychiatrists* of patients in their programs to ensure effective communication, planning and coordination of services.

(26) Each region of the Province should have sufficient inpatient psychiatry beds to meet the needs of the acutely mentally ill population.

(27) Each region of the Province should be relatively self-sufficient in its ability to assess and treat episodes of acute psychiatric illness in its population.

(28) Each general hospital in British Columbia should be prepared to assess and treat all acute episodes of mental illness.

(29) Each general hospital should be designated under the *Mental Health Act* to allow for detention and treatment of individuals with mental illness.

(30) *Local general hospitals* without psychiatric units should have a secure room capability in their emergency department to handle hard-to-manage patients. There should be protocols in place to transfer these patients, if required, to the *district general hospital* with a psychiatric unit within the region.

(31) Each general hospital with a psychiatric unit should have a *secure room* capacity within the unit to manage and/or detain patients who are resistive or combative.

(32) An *intensive acute care psychiatric unit* should be developed in the Vancouver area to handle patients experiencing acute episodes of mental illness and who are also too violent or disruptive to be stabilized and treated in general hospital psychiatry units.

(33) Specialty psychiatric beds should be reserved for university teaching hospitals in the number and type to meet approved academic and research commitments.

(34) Planning and allocating of specialty psychiatric beds should be done in a consultative and coordinated way with the Hospital Programs and Mental Health Services Divisions of the Ministry of Health, and the University of British Columbia, Department of Psychiatry.

(35) The commitment to provide medium/long-term psychiatric inpatient care for the most seriously mentally ill and "at risk" patients should be reaffirmed.

(36) A plan should be developed for up to 550 beds in small units for medium/long-term psychiatric inpatient care in strategic locations of the Province.

(37) Medium/long-term inpatient units should be developed as part of a constellation of services for the chronically mentally ill in conjunction with local Community Mental Health Centres or Community Care Teams.

(38) The Community Mental Health Centre or Community Care Team should take responsibility for managing/coordinating the array of local services for the care of the chronically mentally ill.

Protocols should be developed between local general hospitals providing emergency and short term psychiatric treatment and the Community Mental Health Centre or Community Care Team providing outpatient treatment/management, day/rehabilitation, residential, and medium/long-term inpatient psychiatric care.

(39) The medium/long-term inpatient psychiatric service units should develop a special "umbrella" capacity to plan and coordinate specialty clinical programs and academic research initiatives.

(40) 550 beds for medium/long-term psychiatric inpatient care should be distributed throughout the Province in the following manner:

Vancouver/Lower Mainland	300 beds
Okanagan/Kootenay	100 beds
Vancouver Island	100 beds
North	50 beds

(41) Resources should be dedicated to strengthening a local community-based care model for elderly persons with mental illness.

(42) The development of mental health services for the elderly should be in conjunction with existing health care resources.

(43) The Mental Health Services Division should develop multidisciplinary outpatient teams associated with Community Care Teams and Mental Health Centres around the Province to provide back-up assessment and consultation to general practitioners, local hospitals, and continuing care facilities looking after elderly people with mental illness.

(44) The geriatric assessment and treatment outpatient teams should also develop a community support program for individuals living in their own homes and for families providing care for their elderly relatives.

(45) The Mental Health Services Division should manage a number of local specialized mental health residential care beds for the elderly, offering respite and short term residential care as a further support to families and continuing care facilities in the area.

(46) The Mental Health Services Divison should redevelop a limited number of hospital beds for medium-term specialized inpatient assessment and treatment of the elderly mentally ill, as part of the overall strategy for medium/long-term psychiatric inpatient care.

(47) Mental Health Services Division should provide opportunities and funds for evaluation and applied research related to specialized assessment and treatment methods for elderly mentally ill people.

(48) Mental Health Services Division should continue to take the lead role on behalf of the Government for providing the integration, coordination, and accountability concerning all services for the mentally ill among Ministries of the Provincial Government, Divisions of the Ministry of Health, and other appropriate nongovernment bodies which receive Government funding.

(49) Mental Health Services Division should work closely with Hospital Programs for policy development, program planning, and funding for all *in-hospital mental health care*.

(50) Broadly constituted Mental Health Advisory Boards should be formed within each region to advise Regional Managers of Mental Health Services regarding program needs, policy, and operational issues for the care of mentally ill persons in the area.

(51) Members should be appointed by the Minister of Health to represent key areas of the service system, with significant representation assured for general citizen and patient interest groups.

(52) For the purposes of planning, coordinating, and managing Provincial Mental Health Services, the Province should be divided into six regions:

a) North
b) Vancouver/Richmond
c) Burnaby
d) Fraser Valley/North Shore
e) Vancouver Island
f) Okanagan/Kootenays

(53) At local levels within each region *mental health coordinating committees* should be strengthened or developed to help define service needs, solve operational problems, and improve the abilities of programs working together for the benefit of mentally ill persons.

(54) A coordinated manpower strategy should be developed, for recruitment, placement, and maintenance of mental health professionals in non urban areas of the Province.

(55) The Mental Health Services Division should have ongoing consultation and liaison with B.C. professional training schools to promote a community mental health focus in their relevant courses and supervised practica or internship programs.

(56) The Department of Psychiatry, University of British Columbia, in cooperation with the BCMA Section of Psychiatry, should provide comprehensive continuing psychiatric education aimed at increasing the knowledge and skills of *primary care physicians* in British Columbia.

(57) The Ministry of Health should consult with the various unions representing Riverview Hospital employees within the terms of the relevant collective agreements.

(58) Implementation planning should address the interdependent need of the future service system and Riverview Hospital staff, particularly the large group of psychiatric nurses, to ensure that staff with specialized training and expertise are available to those individuals in need of care and treatment, and at the same time that current staff are assisted in taking on the new roles that will be required of them in future.

(59) There should be a formal relationship between the Mental Health Services Division and universities in British Columbia to coordinate planning for mental health research.

(60) The Mental Health Services Division should establish a Centre for Mental Health Research and Development to coordinate research initiatives for treatment, technological developments, and demonstration projects designed to achieve advancements in mental health care.

(61) The current level of financial resources at Riverview Hospital should be available for treatment, rehabilitation, and support of the mentally ill people transferred to community-based facilities and programs.

(62) A joint commitment should be made by the Hospital Sector and the Ministry of Health to the legitimate needs of the mentally ill for hospital treatment.

(63) Replacement facilities or programs in community settings must be in place prior to any reductions or adjustments to existing facilities and programs at Riverview Hospital.

(64) Bridge funding must be available to permit the development of community-based facilities and programs while Riverview Hospital is gradually being scaled down.

(65) Implementation should be gradual and orderly with ongoing monitoring and evaluation to assure that adjustments to the mental health system are meeting the needs of the mentally ill.

(66) The consultative process should continue over the implementation period to assure that local priorities and needs for mental health services are being addressed.

(67) Patient transfers to community programs should be based on clinical assessment of need and ability, and should involve discussion with family members.

(68) Staffing changes required as part of the implementation process should be planned and carried out by the Ministry in consultation with the relevant unions to minimize the disruption or dislocation felt by individual staff members through appropriate staging, training, deployment, and counselling within the terms of the various collective agreements.

APPENDIX D

LIST OF CONTRIBUTORS

List of Contributors

A large number of individuals and organizations contributed to the planning process through discussions and/or submissions of written briefs. The following list, while not complete, is representative of the variety of viewpoints presented and considered during the consultative planning process.

NAME	LOCATIONS
Abbotsford Mental Health Centre — Mr. Peter Adrian, Director	Abbotsford
Abbotsford Old Age Pensioners Organization — Mr. and Mrs. J. D. Mitchell	Abbotsford
Allan, Dr. C. — Physician	Langley
Allen, Dr. S. — Physician	Langley
Alzheimer Support Association of British Columbia	Vancouver
Anderson, Dr. V. — Physician — Langley Psychiatric Services Planning Committee	Langley
Anhorn, Ms. Margorie — Public Health Nurse	Langley
Appleby, Mr. B. — Director, Dewdney/Allouette Regional District Board of Health	Langley
Arato, Dr. J. — Physician	Langley
Arnason, Mrs. Muriel — Alderman, Langley Municipality	Langley
Arneil, Mr. C. — Administrator, Delta Hospital	Delta
Asche, Dr. G. A.	Hope
Asche, Dr. U. V.	Hope
Aspinall, Dr. H, — Physician	Langley
Association of Professional Social Workers	Vancouver
B.C. Nurses Union — Pamela Moore, Senior Labour Relations Officer	Vancouver
B.C. Pensioners Organization — Dr. J. Crosby Johnson, Director	Coquitlam
B.C. Pricare Association — Mr. Dwight Bailie	Vancouver
Baase, Ms. Marlene — Homemakers	Terrace
Bacchus, Dr. R. — Physician	Langley
Badowski, Mr. Tony — Staff Sergeant, Mission R.C.M.P.	Mission
Bako, Ms. Betto, Long Term Care Nurse	Langley
Bailey, Dr. Arthur — Medical Health Officer — Central Fraser Valley Health Unit	Maple Ridge
Baldini, Mr. Maurizio	Victoria
Bartel, Dr. S. A.	Chilliwack
Bayley, Mr. C. M.	Victoria
Bell, Mr. H. F.	Victoria
Birnie, Ms. Sharon — Director, Langley Adult Day Care	Langley
Bingham, Mr. Paul — Long Term Care, Administrator	Chilliwack
Black, Mrs. Fran — Day Care Nurse Therapist, M.S.A. Hospital	Abbotsford
Blackmore, Dr. R. — Physician	Langley
Blackwood, Dr. — Physician	Maple Ridge
Bogyo, Mr. Grant — Prince Rupert Ministerial Association	Prince Rupert
Bolster, Mrs. Rosemary — Trustee, Langley School District	Langley
Boness, Mr. Glen	Victoria
Bonham, Ms. Helen — Nursing Supervisor, Central Fraser Valley Health Unit	Maple Ridge
Brady, Mr. Alf — Ministry of Social Services and Housing	Prince George
Bray, Ms. Joan — Board Chairperson, Houston Health Care Services Society	Houston
Bright, Dr. B. — Psychiatrist	Maple Ridge
Bright, Dr. H.	Chilliwack
Brinton, Mr. P. — Supervisor, District Counselling Services	Abbotsford
British Columbia Association of Social Workers	Vancouver
British Columbia Government Employees Union — Mr. Gary Steeves	Vancouver
British Columbia Government Employees Union — Mr. John Shields	Vancouver
British Columbia Health Association	Vancouver
British Columbia Medical Assn — Section of Psychiatry — Dr. Perry Lydon	Victoria
British Columbia Medical Association — Ad Hoc Committee	Vancouver
Brodie, Ms. Claire Ann — Home Nursing Care — Skeena Health Unit	Prince Rupert
Brooks, Ms. Ina	Victoria
Brown, Dr. W. — Department of Psychiatry, UBC	Vancouver
Brynjolfson, Dr. J. — Physician	Langley
Bull, Dr. Ronald Keith	Chilliwack

NAME	LOCATIONS
Burnaby Psychiatric Services — Dr. Bill Holt, Director	Burnaby
Burns, Dr. James — Psychiatrist	Surrey
Cabott, Mrs. Mae — Alderman, Maple Ridge	Langley
Cameron, Mr. Ron — Trail Mental Health Centre	Trail
Campbell, Dr. J. W.	Chilliwack
Campbell River and District General Hospital — Mr. W.A. Sharkey, Chairman	Campbell River
Campbell River Mental Health Centre	Campbell River
Canadian Medical Health Association — B.C. Division	Vancouver
Canadian Mental Health Association — Kelowna Branch, Ms. Helen J. Holyk, President	Kelowna
Canadian Mental Health Association — Marilyn Stebbe, Chair, Service Planning Comm.	Vancouver
Capital Mental Health Association — Mrs. Gail Simpson	Victoria
Capital Region Mental Health Services — Dr. G. Johnson, Ms. G. Millbank, Dr. Peter Shieldrop	Victoria
Capital Regional District Health Services	Victoria
Ceresney, Dr. F. — Physician	Langley
Chalifoux, Mr. Dennis — Head of Social Services, Langley Memorial Hospital	Langley
Chafe, Dr. A. — Physician, Psychiatric Sub Committee, M.S.A. Hospital	Abbotsford
Chandler, Dr. D. — Physician	Langley
Chilliwack General Hospital — Mrs. E. Richmond, Mr. W.A. Hiller, Mr. L. Peabody, Mr. M. Coleman	Chilliwack
Chilliwack Mental Health Centre	Chilliwack
Chin, Dr. M. — Physician	Langley
Chou, Dr. B. — Physician	Langley
Chung, Mr. Eugene — Psychiatric Social Worker, Mental Health Services	Vernon
Ciavarella, Dr. A. — Physician	Langley
Citizens Counselling Centre	Victoria
Clappa, Ms. Mary — Dist. Supervisor North, Ministry of Social Services & Housing	Delta
Clarke, Mr. Allan — Psyhciatric Social Worker, Mental Health	Langley
Clarke, Dr. M. — Physician	Langley
Clary, Ms. Carol — Homemakers	Prince George
Cleven, Mrs. Perry — Alderman, Mission	Langley
Cliffe, Ms. Lorna — Senior P.H.N., Upper Fraser Valley Health Unit	Abbotsford
Clunas, Dr. D. — Physician	Langley
Coburn, Dr. Harris C. — Medical Staff	Terrace
Cole, Ms. Donna — Head Nurse, Extended Care, Langley Memorial Hospital	Langley
College, Dr. A. D.	Chilliwack
Condon, Dr. C. — Physician	Kitimat
Cook, Ms. Elizabeth — Northwest Drug and Alcohol Counselling	Terrace
Coolaide	Victoria
Cooper, Dr. H. — Physician	Langley
Copeland, Ms. Lorna — Administrator Terrace and Dist. Community Services Society	Terrace
Coppinger, Mr. S. J.	Victoria
Corkal, Dr. J.	Chilliwack
Cosmetic Facial Surgery Clinic — Dr. J. Dmytryshyn	Vancouver
Coulter, Dr. W. — Physician	Langley
Council of Senior Citizen's Organizations of B.C. — Ms. Evelyn E. Olsen, Secretary	Burnaby
Courtenay Mental Health Centre	Courtenay
Cousins, Ms. D. — Head Nurse, Psychiatry, M.S.A. Hospital	Abbotsford
Craddock, Dr. B., Physician	Terrace
Cram, Dr. G. A.	Chilliwack
Cranbrook Mental Health Centre	Cranbrook
Cudmore, Dr. Richard	Squamish
Cullen, Mr. G. Bruce — Executive Director, Maple Ridge Hospital	Maple Ridge
Cuminsky, Ms. Brenda — Vocational Rehabilitation	Terrace
Cumming, Ms. Millie — Doctors' Services Wrinch Memorial Hospital	Terrace
Cyr, Dr. W.	Abbotsford
Darley, Dr. D. — Psychiatrist, Mental Health Centre	Maple Ridge
Darley, Dr. D. — Psychiatrist, O.P. Program Director, M.S.A. Hospital	Abbotsford
Davies, Dr. G.R. — Medical Director, Royal Inland Hospital	Kamloops
Davies, Mrs. V.A. — Director of Nursing, Valleyview Hospital	Port Coquitlam
Davis, Dr. F. — Physician	Langley
Dawson Creek and District Hospital	Dawson Creek
Dawson Creek Mental Health Centre	Dawson Creek

NAME	LOCATIONS
Delage-Kaufhold, Ms. Danielle — Chairperson, Departmental Study Committee, Riverview Hospital	Port Coquitlam
Delgatty, Ms. Cathy — Director of Nursing, Terraceview Lodge	Terrace
Dell, Mrs. Jean	Victoria
Delmarque, Ms. Connie — Social Worker, Mills Memorial Hospital	Terrace
Delta Mental Health Centre — Ms. Jill Blake-White	Delta
Deltassisi	Delta
DeMontigny, Dr. P.	Chilliwack
Denton, Mrs. Jane — Trustee, Maple Ridge/Pitt Meadows School District	Langley
Department of Psychiatry — University of B.C.	Vancouver
Devilliers, Dr. S. — Mental Health and Hospital Psychiatrist	Prince George
Dick, Dr. E.W. — Physician, M.S.A. Hospital	Abbotsford
Dobyn, Ms. Bev — Acropolis Manor	Prince George
Doran, Dr. W. — General Practitioner, Houston Health Centre	Houston
Dornon, Dr. K. — Physician	Langley
Doyle, Mr. Gordon	Squamish
Dubois, Dr. — Chairman, Psychiatric Services Committee	Chilliwack
Dueck, Dr. John — General and Vascular Surgeon	Chilliwack
Dufresne, Ms. Estelle — Nutrition, Health Unit	Langley
Duke, Dr. D. C.	Hope
Dunbar, Mr. Timothy	Victoria
Duncan Mental Health Centre	Duncan
Dziny, Ms. C. — Director, Probation Services	Squamish
Educators for Seniors — Mr. Dave Jaffe	Vancouver
Elliott, Mrs. Lois E.	Surrey
Elliott, Ms. Gwen	Victoria
Ellis, Major Jack, O.I.C. — Base Hospital, C.F.B.	Masset
Elms, Ms. Pat — Director of Nursing, Mission Memorial Hospital	Maple Ridge
Emergency Services Committee — Dr. Barry Morrison	Vancouver
English, Dr. Bill — Supervisor, Ministry of Social Services and Housing	Maple Ridge
Enns, Dr. George	Chilliwack
Erskine, Mr. and Mrs. J. F.	Sidney
Esmail, Dr. M. — Family Physician	Chilliwack
Evans, Dr. S. V.	Chilliwack
Eyres, Ms. Sherriel	Victoria
Fane, Ms. Marilyn — Community Services,	Chilliwack
Faulkner, Ms. Harriett — Head Nurse Medical, Mission Memorial Hospital	Mission
Fedewa, Ms. Ruth — Chairperson, Burnaby Friends of Schizophrenics	Burnaby
Fernandes, Dr. C. — Chief of Staff, Maple Ridge Hospital	Maple Ridge
Fleming, Ms. Rose Marie — Parents in Crisis	Prince George
Flett, Ms. Claudia — Ministry of Social Services and Housing	Prince George
Flowers, Mrs. Betty R.	Victoria
Flynn, Dr. B. N.	Chilliwack
Ford, Ms. Marjorie — Mental Health Network Program	Prince George
Forrest, Dr. F. — Physician	Langley
Friends of Schizophrenics	Campbell River
Friends of Schizophrenics	Kelowna
Friends of Schizophrenics	Vancouver
Friends of Schizophrenics — Ms. Joan Deering, President	North Shore
Friends of Schizophrenics — Mr. T.W. Maglio, Chairman	Coquitlam
Friends of Schizophrenics — Ms. Viola Kiess	Victoria Chapter
Friendship House — Mr. Fred Anderson	Prince George
Frost, Ms. Sally — Head of Occupational Therapy, Langley Memorial Hospital	Langley
Frye, Dr. J. — Mental Health and Hospital Psychiatrist	Prince George
Frye, Dr. R. — Mental Health and Hospital Psychiatrist	Prince George
Fuller, Dr. L. — Psychiatrist, Program District, Psychiatric Inpatient	Abbotsford
Furgeson, Dr. — Physician	Delta
Galbraith, Ms. Audere	Victoria
Gallagher, Dr. — Physician	Maple Ridge
Geddes, Ms. Anne — Nursing Consultant, Preventive Services	Victoria
Gerdes, Ms. E. — Head of Public Health	Terrace
Gerontology Association of B.C. — Ms. Jean M. Taylor, Dr. B. Burnside	Vancouver

NAME	LOCATIONS
Glover, Ms. L. — Prince George Regional Hospital	Prince George
Graham, Ms. Dorothy — Prince Rupert Regional Hospital	Prince Rupert
Graham, Dr. — Chief of Staff, Mission Memorial Hospital	Mission
Gray, Ms. Elaine — Community Nurse	Chilliwack
Green Clinic	Cranbrook
Gubbins, Dr. W. G. — Physician	Langley
Gutowski, Dr. W. D.	Chilliwack
Hackett, Dr. John D.	Victoria
Halucschak, Ms. Marg — Public Health	Langley
Hannah, Ms. Gail — Ministry of Social Services and Housing	Prince George
Harris, Mr. William — Alderman, Mission	Langley
Hassell, Mr. and Mrs. Dick	Surrey
Hayden, Dr. Huguette — Psychiatrist — Langley Psychiatric Svcs. Planning Committee	Langley
Hayes, Mr. C. — Regional Manager, Ministry of Social Services and Housing	Prince George
Hazelmere Lodge — Mr. Arnold Neufeld	Surrey
Hein, Dr. Murray — Emergency Medical Officer, Delta Hospital	Delta
Heller, Dr. B. — Physician	Langley
Herdman, Dr. J.R. — Riverview Hospital Medical Staff	Port Coquitlam
Hiche, Ms. Arleen	Victoria
Hilliard, Dr. N.	Chilliwack
Hirst, Dr. Ken R.	Chilliwack
Ho, Dr. Kay — Family Physician	Chilliwack
Hodge, Dr. Gillian — Physician	Terrace
Hoffer, Dr. A.	Victoria
Holinaty, Mr. Richard — Executive Director, Langley Memorial Hospital	Langley
Hoogewerf, Dr. P. — Physician and Chief of Medical Staff, M.S.A. Hospital	Abbotsford
Hopkins, Dr. Thomas M. — Family Physician	Vancouver
Horvat, Mr. Lee	Vancouver
Hospital Issues Committee — Dr. Maelor Vallance	Vancouver
Hospital Social Work Directors Society of British Columbia	Burnaby
Howell-Jones, Dr. H. — Physician	Langley
Huck, Mr. George — Northwest Mental Health Network Advisory Committee	Terrace
Hunter, Dr. — Physician	Delta
Hunter, Mr. Mervin — Alderman	Langley
Hurrell, Ms. Stella	Victoria
Husband, Mr. — Hospital Administrator	Terrace
Hutchinson, Dr. — Physician	Delta
Hutchinson, Ms. Linda — Psychiatric Social Worker	Langley
Hutmacher, Mr. Bob — Executive Director, Delta Hospital	Delta
Hyde, Mr. Terry — Northwest Mental Health Network Advisory Committee member	Terrace
Hyslop, Dr. E. — Physician	Langley
Janze, Ms. Lorna — Wrinch Memorial Hospital	Terrace
Jean, Dr. Pat — Psychologist	Langley
Jones, Dr. Barry D. — Director, Schizophrenia Unit, UBC	Vancouver
Jones, Ms. Moyra — Chairperson, Ad Hoc Committee, Rehabilitation Services, Riverview Hospital	Port Coquitlam
Juan de Fuca Hospital Society — Dr. Duncan Robertson, Director of Geriatric Rehabilitation	Victoria
Kamloops Mental Health Centre	Kamloops
Kasser, Mr. David — Doctors' Services, Wrinch Memorial Hospital	Terrace
Kehler, Dr. L. D. — Physician and Surgeon	Hope
Kelowna General Hospital — Dr. P. R. Latimer	Kelowna
Kelowna Mental Health Centre — Dr. Keith Barnes	Kelowna
Kennelly, Mr. B.R. — Head Nurse, Mills Memorial Hospital	Terrace
Kerr, Dr. C.	Chilliwack
Kitimat/Stikine Regional District — Mrs. Judy Tracey	Kitimat
Klassen, Dr. B. G.	Chilliwack
Klassen, Mr. E. — District Parole Office	Abbotsford
Klingspohn, Ms. Donna — Community Nurse, Mental Health Services	Langley
Kos, Ms. Greta — Public Health Inspector	Langley
Konoree, Dr. Laverne	Squamish
Krumlik, Dr. J. — Physician	Langley
Lamont, Dr. D. — Physician	Langley

NAME	LOCATIONS
Land, Ms. Jan — Probations	Langley
Langley Adult Daycare Centre	Langley
Langley Mental Health Centre	Langley
Last, Mr. Ken — Administrator, Kitimat General Hospital	Kitimat
Leach, Mr. Robert	Victoria
LeClair, Ms. Diane — Nurse, Jackman Manor	Langley
Lennox-Farrally, Ms. Vicki	Delta
Lerner, Mr. Ken — Director, Mental Health Centre	Langley
Leroux, Mr. Dan — Staff Sergeant, RCMP	Squamish
Levens, Mrs. Betty — Trustee, Maple Ridge School District	Langley
Lin, Dr. Tsung-yi — Psychiatrist	Vancouver
Linden, Mrs. Karen — Trustee, Mission School Board	Mission
Lockington, Ms. Anne — Drug and Alcohol Counsellor	Terrace
Lok, Mr. Charles — Stewart R.C.M.P. Detachment	Stewart
Lok, Ms. Elaine — Stewart General Hospital	Stewart
Lowrie, Ms. Josie — Community Psychiatric Nurse	Langley
Luttrell, Ms. M. — Long Term Care Administrator	Terrace
MacAskill, Dr. A. — Physician	Langley
MacCallum, Ms. Ruth — Maple Ridge Mental Health Centre	Maple Ridge
MacDonald, Ms. A. — Associate Director of Nursing, Maple Ridge Hospital	Maple Ridge
MacDonald, Dr. J. — Physician	Langley
MacIntosh, Dr. D. — Physician	Langley
MacKenzie, Ms. Diane, Executive Director — Health Care Society	Masset
MacKenzie, Dr. — Medical Director	Prince George
MacPherson, Dr. Carol — Psychologist	Langley
MacTavish, Dr. L.	Aggassiz
MacTavish, Dr. John N.	Nanaimo
Magarry, Mr. and Mrs. R.	Victoria
Mann, Mrs. Judy — Director of Patient Services, Nursing, Maple Ridge Hospital	Maple Ridge
Maple Ridge — Pitt Meadows District Medical Association — Dr. R.G. Harrison, President	Maple Ridge
Maple Ridge Hospital	Maple Ridge
Maple Ridge Mental Health Centre — Dr. Alan Rendle, Director	Maple Ridge
Marten, Ms. Diana — Acting Supervisor, Ministry of Social Services and Housing	Mission
Martin, Dr. J. — Physician	Langley
Mary Street Medical Association	Chilliwack
Mason, Dr. K. E.	Hope
Materie, Ms. Sue — Stewart Secondary School	Stewart
Matheson, Dr. J. — Physician	Langley
Matic, Mrs. Voika	Vancouver
Matsqui Police — Mr. J. Stewart, Chief of Police	Matsqui
Mayes, Ms. Candace — Hearing, Health Unit	Langley
McCarthy, Ms. Jeannine — Head Nurse, Operator at Trinity and Simpson Lodges	Langley
McCormick, Mr. Lindsay — Social Service Department, Valleyview Hospital	Port Coquitlam
McGonigal, Ms. Shirley — Head Nurse, Medical Surgery, Langley Memorial Hospital	Langley
McInnes, Mr. Bill — Health Unit	Chilliwack
McInnes, Dr. Wm. — Medical Health Officer, Upper Fraser Valley Health Unit	Abbotsford
McKaque, Ms. Marilyn	Vancouver
McKenzie, Ms. Carol — Head Nurse, Emergency Services, Langley Memorial Hospital	Langley
McLay, Mr. Dave — Superintendent, RCMP	Chilliwack
McParland, Mr. Brian — Supervisor, Ministry of Social Services and Housing	Maple Ridge
McKeown, Ms. Gretel — Ministry of Social Services and Housing	Terrace
McKinlay, Dr. David — Psychologist	Langley
Meiorin, Mr. Leo	Trail
Messing, Dr.	Cranbrook
Miki, Dr. P. — Physician	Langley
Miles, Dr. James E. — Professor/Head, Department of Psychiatry, UBC	Vancouver
Mill, Ms. Alicia — Owner/Operator, Good Shephard	Langley
Miller, Dr. M. — President, Medical Staff, Langley Memorial Hospital	Langley
Minion, Dr. R. K.	Agassiz
Ministry of Attorney General — Corrections Branch — Mr. B.G. Robinson, Commissioner	Vancouver
Mission Memorial Hospital — Mr. Neville Cox, Executive Director	Mission

NAME	LOCATIONS
Mission Oaks Medical Centre — Dr. C.M. Blackwood	Mission
Mohammed, Dr. S.N. — Chief of Psychiatry, Royal Inland Hospital	Kamloops
Moleche, Ms. Heather — Occupational Therapist, Langley Memorial Hospital	Langley
Moore, Dr. A. — Physician and Chairman, Psychiatric Sub Committee, M.S.A. Hosp.	Abbotsford
Moore, Ms. Denise — District of Stewart	Stewart
Moore, Mrs. E. E.	Victoria
Moore, Ms. Sally — Resource Worker, Ministry of Social Services and Housing	Terrace
Morgan, Mr. Alex	Victoria
Morisette, Mr. Kenneth G. — Information Officer, Riverview Hospital	Port Coquitlam
Morrissey, Mrs. Lucy	Vancouver
Mout, Dr. R. — Physician	Langley
Muir, Dr. Phil — Physician, Wrinch Memorial Hospital	Terrace
Mulder, Mr. L.R. — Staff Sergeant	Fort St. John
Munroe, Inspector K. — Langley R.C.M.P.	Langley
Murakami, Dr. E. K. — Physician and Surgeon	Hope
Murray, Ms. Elaine — Reg. Mgr./01, Ministry of Social Services and Housing	Fraser Valley
Nair, Dr. N. G. — Psychiatrist	Langley
Nanaimo Mental Health Centre	Nanaimo
Nanaimo Regional General Hospital — Mr. B. Holden	Nanaimo
Nataros, Dr. G. — Physician	Langley
Neilson, Dr. G. — Physician	Langley
Nelson, Dr. D. — Physician	Langley
Nelson Mental Health Centre	Nelson
Nelson, Ms. Shirley A. — Administrator Houston Health Centre	Houston
New View Society	Port Coquitlam
New Westminister Mental Health Centre — Mrs. H. Dahling	New Westminster
Newbury, Dr. Peter — Physician, Wrinch Memorial Hospital	Terrace
Newcombe, Dr. K. — Family Physician	Chilliwack
Ng, Dr. K. — Physician	Langley
Noble, Dr. V. K.	Chilliwack
Noore, Mr. Garry — District Supervisor, Ministry of Social Services and Housing	Squamish
North Shore Community Mental Health Planning Committee — Dr. Donald Watterson	North Shore
North Shore Mental Health Centre — Mr. D. Turner	North Shore
Nunoda, Mrs. Toyo — Social Worker, Ministry of Social Services and Housing	Terrace
O'Brien, Dr. M. — Physician	Langley
Ouwehand, Mrs. R. — Alderman, Pitt Meadows	Langley
Paetkau, Mr. W. — Director, M.S.A. Community Services, School District /34	Abbotsford
Page, Dr. R. — Physician	Terrace
Pankratz, Dr. E. — Physician	Langley
Parsons, Dr. T. — Physician	Langley
Patacco, Ms. Heather — Nurse Assessor, Long Term Care	Squamish
Paul, Dr. V. — Physician	Langley
Pauls, Dr. Henry	Chilliwack
Pawley, Ms. Cathy — Nurse, Evergreen Lodge	Langley
Peace Arch District Hospital — Mrs. V. Curtis, Executive Director	White Rock
Peglar, Dr. M. — Physician	Langley
Penrose, Ms. Mary Lea — Skeena Health Unit	Prince Rupert
Penticton Mental Health Centre — Ms. Edna M. Little	Penticton
Petipas, Mrs. Chris — Trustee, Langley School District	Langley
Phelps, Dr. A. H.	Chilliwack
Port Alberni Mental Health Centre	Port Alberni
Port Coquitlam Mental Health Centre	Port Coquitlam
Pos, Dr. Robert	Vancouver
Poulos, Ms. Susan, Mananger, Woodlands	New Westminster
Powell River Mental Health Centre	Powell River
Pretos, Dr. H. — Urologist	Chilliwack
Price, Ms. Barbara — Nutritionist, Public Health	Langley
Prince George Mental Health Centre — Ms. Sheri Senum	Prince George
Prince Rupert Mental Health Centre	Prince Rupert
Professional Employees Association — Ms. Della F. Risley	Vancouver
Proznick, Mr. Nick — Ministry of Social Services and Housing	Langley

NAME	LOCATIONS
Psychiatric/Mental Health Nurses Interest Group	Victoria
Pushie, Dr. M. — Physician	Langley
Quesnel Heights Womens Support Group	Vancouver
Quesnel Mental Health Centre	Quesnel
Quinn, Dr. E. A.	Chilliwack
RADAT (Richmond Alcohol and Drug)	Richmond
Rai, Mr. F. — District Supervisor, Ministry of Social Services and Housing	Abbotsford
Raymond, Dr. Jan	Squamish
Rayson, Dr.	Cranbrook
Registered Nurses Association of B.C. — Ms. Pat Cutshall, Executive Director	Vancouver
Registered Psychiatric Nurses Assoc. of British Columbia — Mr. Ross A. Stewart	Burnaby
Rhodes, Mr. Don — Speech Therapist, Health Unit	Langley
Richardson, Mr. Ross — Prince Rupert Regional Hospital	Prince Rupert
Richmond, Dr. A.	Chilliwack
Richmond General Hospital — Dr. E. McKinstry	Richmond
Riverview Hospital Volunteer Association — Ms. Anna Koochin, President	Port Coquitlam
Roark, Mr. Tim — Public Health Inspection	Langley
Robinson, Dr. D. — Physician	Langley
Rogers, Dr. Derrick H. — Physician and Surgeon	Chilliwack
Rostvig, Dr. L. — Physician	Langley
Royal Columbian Hospital — Dr. C. Kogan, Chief of Psychiatry	New Westminster
Runions, Dr. J.E. — Clinical Director, Riverview Hospital	Port Coquitlam
Russell, Mr. John — Executive Director, Greater Vancouver Mental Health Services	Vancouver
Rutz, Dr. H. — Chief of Staff, Langley Memorial Hospital	Langley
Saad, Dr. Ali — Psychiatrist, M.S.A. Hospital	Abbotsford
Saanich Mental Health Centre — Ms. Gayle Millbank	Saanich
Salmon Arm Mental Health Centre	Salmon Arm
Sanders, Ms. Marg — Long Term Care	Langley
Sawer, Dr. Ben — Physician	Chilliwack
Schellonberg, Dr. Ken	Squamish
Schilling, Dr. R. — Physician	Langley
Schmidt, Ms. Noni — Langley Homemakers	Langley
Schwab, Mr. B. — Skeena Health Unit	Skeena
Scott-Ashe, Dr. R. — Physician	Langley
Seal, Dr.	Victoria
Searl, Mr. Aubrey — Alderman, Langley Municipality	Langley
Sebastian, Mr. Don	Victoria
Sechelt Mental Health Centre	Sechelt
Secord, Ms. Goldie — Outreach — Houston Health Centre	Houston
Serac, Ms. Bea — Social Worker, Ministry of Social Services and Housing	Prince Rupert
Shaughnessy Hospital — Dr. Jonathan Fleming, Acting Head, Department of Psychiatry	Vancouver
Sheffield, Dr.	Cranbrook
Shin, Dr. M. — Physician	Langley
Shirley, Dr. D. — Physician	Langley
Shore, Dr. S. — Physician	Langley
Silver Threads Service — Mrs. Pauline Barker, Executive Director	Victoria
Sim, Dr. Myre	Victoria
Simkus, Dr. R. — Physician	Langley
Singleton, Dr. S.	Hope
Sipos, Mr. Steve — Langley School District	Langley
Skinner, Ms. Margaret — Director of Nursing, Langley Memorial Hospital	Langley
Sleigh, Mr. F. — Director, Dewdney/Allouette Regional District Board of Health	Langley
Smart, Dr. J. — Physician	Langley
Smith, Ms. Charlotte — Hazelton and Area Home Support Services	Hazelton
Sommers, Ms. Karen — Director, Langley Stepping Stones Society	Langley
Spicer, Ms. Ann — President, Long Term Care Citizen's Assoc. of South Van. Island	Victoria
Squamish General Hospital — Mr. John Diccabough	Squamish
Squamish Mental Health Centre	Squamish
St. Felix Church — Sisters Anne and Francis	Terrace
St. Joseph's Hospital — Dr. F. William Halliday, Chairman Psychiatric Division	Comox
St. Loius, Dr. A. — Physician	Langley

NAME	LOCATIONS
St. Paul's Hospital — Dr. Conrad J. Schwarz, Chairman, Deparment of Psychiatry	Vancouver
St. Vincent's Hospital — Dr. Alex R. Yarrow	Vancouver
Stephany, Dr. H. — Physician	Langley
Sterritt, Ms. Barb. — Medical Services	Terrace
Stewart, Ms. Doris, Director of Patient Services, Langley Memorial Hospital	Langley
Stickney, Ms. Maureen — Long Term Care, Skeena Health Unit	Skeena
Stiles, Ms. Vi	Victoria
Stockdill, Dr. D. — Physician	Langley
Stokes, Mr. John — Social Worker, Ministry of Social Services and Housing	Terrace
Surrey Memorial Hospital — Dr. J. Gillies, Vice-President (Medical)	Surrey
Surrey Mental Health Centre — Ms. Hazel Udhic, Director	Surrey
Surrey Rehabilitation Society	Surrey
Surrey/Delta Psychiatric Liaison Committee — Ms. Linda Syssoloff, Chairperson	Surrey/Delta
Suwala, Mr. Dennis — Regional Manager, Mental Health Services	Nanaimo
Swanney, Dr. J. — Physician, M.S.A. Hospital	Abbotsford
Sych, Ms. Barri — Nurse, Langley Lodge	Langley
Takahashi, Ms. Wendy — Skeena Health Unit	Smithers
Tam, Dr. Michael S. K.	Chilliwack
Tamkin, Ms. Eleanor	Vancouver
Taylor, Ms. Rose — Nurse, Owner/Operator, Murrayville Manor	Langley
Teichroeb, Dr. Wm. — District Supervisor, Ministry of Social Services and Housing	Abbotsford
Terrace Mental Health Centre — Mr. Bill Herriot	Terrace
Thomas, Mr. Hamilton — Ministry of Social Services and Housing	Langley
Thomasson, Ms. Judy — Head Nurse, Medical I.C.U. Ward, Maple Ridge Hospital	Maple Ridge
Tielsens, Dr. R. — Physician	Langley
Tindall, Mr. Doug — Ministry of Social Services and Housing	Langley
Tingey, Dr. R. — Family Physician	Chilliwack
To, Ms. Lilian — Residential Care Social Worker, Mental Health	Langley
Tod, Ms. Linda — Psychiatric Geriatric Social Worker	Langley
Todd, Dr. N.	Chilliwack
Trail Mental Health Centre	Trail
Travis, Ms. Marlene — Skeena Health Unit	Skeena
Tremblay, Ms. Marjorie — Nurse Houston Health Centre	Houston
Trott, Ms. Marg — Parkholm	Chilliwack
Union Board of Health	Delta
Union of Psychiatric Nurses — Mr. Dwight L. Wenham, Director, Labour Relations	Coquitlam
Valhenke, Ms. Pauline — Occupational Therapy, Mills Memorial Hospital	Terrace
Van de Kamp, Dr. L.A.	Victoria
Vancouver General Hospital — Dr. D. J. McLure, Prof. & Head, Dept. of Psychiatry	Vancouver
Vernon Mental Health Centre	Vernon
Victoria Mental Health Centre	Victoria
Visser, Ms. Elizabeth — Operator, Highland Lodge	Langley
Voth, Dr. C. G.	Chilliwack
Voth, Mr. Terry — Social Worker, M.S.A. Hospital	Abbotsford
Wakefield, Ms. Jane, Psychologist, Vernon Mental Health Centre	Vernon
Wallace, Dr. C. — Physician, Psychiatric Sub Committee, M.S.A. Hospital	Abbotsford
Walter, Ms. J. — Boarding Home Program, Mental Health Services	Prince George
Weatherstone, Dr. Philip — Physician	Chilliwack
Weeden, Dr. D. R. P.	Chilliwack
West Coast General Hospital — Dr. H.W. Webster	Port Alberni
Western Communities Mental Health Centre	Victoria
Whalley Mental Health Centre	Whalley
Wharf, Dr. Brian — Dean, Department of Human Development, U.Vic	Victoria
Whetter, Dr. A. R.	Chilliwack
White Rock Coordinating Centre — Mr. Tim Beachy	White Rock
White Rock Zone Committee	White Rock
Williams, Ms. June — Home Care, Health Unit	Langley
Williams Lake Mental Health Centre — Mr. Roland Perrin, Director	Williams Lake
Williams, Mr. Len — Psychiatric Social Worker	Langley
Wills, Ms. Anne — Administrator, Osborne Home	Terrace
Wilson, Dr. I	Chilliwack

NAME	LOCATIONS
Wilson, Dr. K	Chilliwack
Wilson, Dr. R. — Physician	Langley
Wilson, Mr. Pat — Inspector, Superintendent, Maple Ridge R.C.M.P.	Maple Ridge
Wolchok, Dr. G. — Physician	Langley
Wooff, Mr. Harvey — Staff Sargent — Maple Ridge R.C.M.P.	Maple Ridge
Woolridge, Dr. David — Geriatric Assessment Centre, Greater Victoria Regional Hospital Society	Victoria
Worthington, Mr. S. — Administrator, M.S.A. Hospital	Abbotsford
Wragg, Ms. Shirley and Mr. R. H.	Victoria
Yorke, Dr. A. — Physician	Langley
Young, Dr. Archie A. D.	Chilliwack
Young, Dr. Drew A. B.	Chilliwack

APPENDIX E

REFERENCES

There is extensive literature in a variety of disciplines addressing the many issues related to the care of the mentally ill. The following bibliography, while lengthy, is by no means exhaustive, and is representative of some of the material reviewed by the many people who have participated in the production of the Mental Health Consultation Report.

Anthony, William A.; Cohen, Mikal R.; and Cohen, Barry F. *Philosophy, Treatment Process, and Principles of the Psychiatric Rehabilitation Approach*, New Directions for Mental Health Services, San Francisco, Jossey-Bass, No. 17, March 1983.

Anthony, William A.; Cohen, Mikal R.; and Vitalo, Ray. *The Measurement of Rehabilitation Outcome*, Schizophrenia Bulletin, Vol. 4, 1978.

Bachrach, Leona L. *Asylum and Chronically Ill Psychiatric Patients*, American Journal of Psychiatry, August 1984.

Bachrach, Leona L. *An Overview of Deinstitutionalization* New Directions for Mental Health Services, San Francisco, Jossey-Bass, No. 17, March 1983.

Bachrach, Leona L. *Concepts and Issues in Deinstitutionalization*. Chronic Psychiatric Patient in The Community Principles of Treatment, Spectrum Publications Inc., 1984.

Bachrach, Leona L. *Asylum and Chronically Ill Psychiatric Patients*, American Journal of Psychiatry, August 1984.

Bachrach, Leona L. *Dimensions of Disability in the Chronic Mentally Ill*, Hospital and Community Psychiatry, Vol. 37, No. 10, October 1986.

Bachrach, Leona L. *Is the Least Restrictive Environment Always the Best? Sociological and Semantic Implications*. Hospital and Community Psychiatry, Vol. 31, No. 2, February 1980.

Bachrach, Leona L. *New Directions in Deinstitutionalization Planning* New Directions for Mental Health Services, No. 17, San Francisco, Jossey-Bass, March 1984.

Bachrach, Leona L. *Planning Mental Health Services for Chronic Patients*, Hospital and Community Psychiatry, Vol. 30, No. 6, June 1979.

Bachrach, Leona L. *The Future of the State Mental Hospital*, Hospital and Community Psychiatry, Vol. 37, No. 5, May 1986, Bassuk, Ellen L.; and Gerson, Samuel. *Deinstitutionalization and Mental Health Services*, Scientific American, Vol. 238, No. 2, February 1978.

Beigel, Allan. University of Arizona College of Medicine, *The Remedicalization of Community Mental Health*, Hospital and Community Psychiatry, November 1984.

Boyd, Jeffrey L.; McGill, Christine W.; and Falloon, Ian R. *Family Participation in the Community Rehabilitation of Schizophrenics*, Hospital and Community Psychiatry, September 1981.

Caton, Carol L.M.; Goldstein, Jill M.; Serrano, Oscar; Bender, Rose. *The Impact of Discharge Planning on Chronic Schizophrenic Patients*, Hospital and Community Psychiatry, March 1984.

Caton, Carol L.M. New York State Psychiatric Institute, Director, *The New Chronic Patient and the System of Community Care*, Hospital and Community Psychiatry, July 1981.

Clave, Juhree Z. *Policy Paper: Designation of Active Treatment Hospital Facilities in Alberta*, Institutional Mental Health Services Section, Provincial Programs Branch, Department of Hospitals and Medical Care, May 1985.

Community Advisory Board, Whitby Psychiatric Hospital *Redevelopment Plan and the Community Care Component*, Ministry of Health, Whitby, Ontario, November 1984.

Dalzeil, Dr. W., Department of Medicine, U.B.C., Geriatrician, Shaughnessy Hospital. *Care of the Elderly: 2001*, Long Term Care, B.C.H.A. News, May 1985.

Davis, Charles; Glick, Ira D.; Roscow, Irving. *The Architectural Design of a Psychotherapeutic Milieu*, Hospital and Community Psychiatry, Volume 30, Number 7, July 1979.

Fedoryk, William, Physical Plan Superintendent, Creedmoor Psychiatric Centre, Queens Village, New York. *On Creating Humane Environments*, Quality Review Bulletin, December, 1980.

Foulkes, R.G. *Health Security for British Columbians*, Queens Printers, 1974.

Foulkes, R.G. *British Columbia Mental Health Services: Historical Perspective to 1961*, CMA/85; Sept. 1961.

Freedman, Ruth I.; and Moran, Ann. *Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization*, Medical Care, Vol. 22, No. 12, December 1984.

Freeman, J.J. *The Chronic Patient Rediscovered: ten propositions*, Canada's Mental Health, December 1983

Goldman, Howard H. Langley Porter Psychiatric Institute, University of California School of Medicine, *Integrating Health and Mental Health Services: Historical Obstacles and Opportunities*, American Journal of Psychiatry, May 1982.

Goldney, R. *The Psychiatric Intensive Care Unit*, Brit. J. Psychiatry 146, 1985.

Hall, E.N. *Canada's National Provincial Health Program for the 1980's — A Commitment for Renewal*. 1980.

Gralnick, Alexander. *Build a Better State Hospital: Deinstitutionalization Has Failed*, Hospital and Community Psychiatry, Vol. 36, No. 7, July 1985,

Hatfield, Agnes B. University of Maryland, *Open Forum: Families As Advocates for the Mentally Ill A Growing Movement*, Hospital and Community Psychiatry, September 1981.

Lamb, H. Richard; and Lamb, Doris M. *A Nonhospital Alternative to Acute Hospitalization*, Hospital and Community Psychiatry, July 1984.

Liberman, Robert P.; Massel, H. Keith; Mosk, Mark D.; Wong, Stephen E. *Social Skills Training for Chronic Mental Patients*, Hospital and Community Psychiatry, April 1985.

Linn, Margaret W.; Gurel, Lee; Williford, William O.; Overall, John; Gurland, Barry; Laughlin, Phil; Barchiesi, Alessandro. *Nursing Home Care as an Alternative to Psychiatric Hospitalization*, Nursing Home Care Arch Gen. Psychiatry Vol. 42, June 1985.

Luke, Dr. E., and Penner, Ron. *Results of Riverview Follow-up Study of Chronic Mental Patients*, July 1981.

McKerracher, D.G. *Trends in Psychiatric Care*, Royal Commission on Health Services 1964.

Mann, W.C. *A Quarterway House for Adult Psychiatric Patients*. The American Journal of Occupational Therapy, 1976.

Marshall, John. Madness: *An Indictment of the Mental Health Care System in Ontario, Ontario Public Service Employees Union, 1982.*

Miller, Jordan A. *Design and Construction - Health Professionals Surveyed for Psychiatric Hospital Design*, Hospitals, February 1981.

More For the Mind. A Study of Psychiatric Services in Canada. Canadian Mental Health Association, 1963.

Okin, R.L., Dolnick, J. *Beyond State Hospital Unitization: The Development of an Integrated Mental Health Management System*. Hospital and Community Psychiatry 36, Nov. 85.

Okin, Robert L. *Expand the Community Care System: Deinstitutionalization can Work*, Hospital and Community Psychiatry, July 1985, Vol. 36, No. 7.

Ozarin, L.D.; and Witkin, M.J. *Halfway Houses for the Mentally Ill and Alcoholics: A 1973 Survey*. Hospital and Community Psychiatry, 1975.

Pardes, Herbert, M.D.; and Stockdill, James W. *Survival Strategies for Community Mental Health Services in the 1980's*, Hospital and Community Psychiatry, February 1984.

Pepper, Bert; Kirshner, Michael C.; Ryglewicz, Hilary. *The Young Adult Chronic Patient: Overview of a Population*, Hospital and Community Psychiatry, July 1981.

Pilon, W.; and Marcotte, C. *The Semi-Community Environment and the Reintegration of the Psychiatric Resident: Present Status and Outlook for the Future*. Canada's Mental Health, 1976.

Purnell, T.L.; Sachson, S.M.; and Wallace, E.C. *A Quarterway House Program for Hospitalized Chronic Patients*. Hospital and Community Psychiatry, 1982.

Recommendations of APA's Task Force on the Homeless Mentally Ill, Hospital and Community Psychiatry, Vol. 35, No. 9, September 1984.

Rice, William W.; Howard, Mary Ellen; and Lammers, Lawrence P. *Size Considerations in the Psych. Unit*, Michigan Hospitals, December 1984.

Richman, A., *Psychiatric Care in Canada. Extent and Results*. Royal Commission on Health Services, 1964.

Ross, M., *Survey of Mental Health Needs and Resources of British Columbia*, Queen's Printer B.C. 1961.

Rubin, Jeffrey, Rutgers University, New Brunswick, New Jersey, *Cost Measurement and Cost Data in Mental Health Settings*, Hospital and Community Psychiatry, September 1982.

Schwartz, Stuart R.; and Goldfinger, Stephen M. *The New Chronic Patient: Clinical Characteristics of an Emerging Subgroup*, Hospital and Community Psychiatry, November 1984.

Scull, Andrew T. *Decarceration - Community Treatment and the Deviant; A Radical View*. Englewood Cliffs, N.J.: Prentice-Hall, 1977.

Shadish, William R., Jr. *Policy Research - Lessons from the Implementation of Deinstitutionalization*, American Psychologist, July 1984.

Social Planning and Review Council of British Columbia. *The Health Needs of the Independent Elderly*. Vancouver: SPARC, 1976.

Stone, Leroy O.; and Fletcher, Susan. *A Profile of Canada's Older Population*. Montreal: Institute for Research on Public Policy, 1980.

Stein, Leonard I.; and Test, Mary Ann. *The Training in Community Living Model: A Decade of Experience*, New Directions for Mental Health Services, Number 26, June 1985.

Test, Mary Ann; and Stein, Leonard L. *Community Treatment of the Chronic Patient: Research Overview*, Schizophrenia Bulletin, Vol. 4, 1978.

Toews, J.; Barnes, G. *Chronic Mental Disorders in Canada*, Health & Welfare Canada, Dec. 1982.

Walker, C.B. *The Emerging Profile of the Aged in Canada*. Paper presented at The Research Symposium on Canada's Changing Age Structure: Implications for the Future, Vancouver, B.C., August 23, 1981.

Wasylenki, D. *Aftercare in a Metropolitan Setting*, Canadian Journal of Psychiatry, Vol. 30, Aug. 1985.

Wasylenki, Donald A. *The Role of the Psychiatric Hospital in Contemporary Psychiatry*, Psychiatry in Canada, Vol. 1, Summer 1986.

Whitehead, Clay; Ellison, Gail; Kerpen, Stephen, and Marshall, David. *The Aging Psychiatric Hospital: An Approach to Humanistic Redesign*, Hospital and Community Psychiatry, November 1976.

Queen's Printer for British Columbia ©
Victoria, 1987